DEPARTMENT OF HEAL			D CERTIFIC	CATION A	CENTERS FOR MED AND TRANSMITTAL	ICARE & MEDICAID SERVICES ID: 5Z1K	
					TE SURVEY AGENCY	Facility ID: 00149	
1. MEDICARE/MEDICAID PROVI NO.(L1) 245223	DER	3. NAME AND AI (L3) RED WING	HEALTH CEN	NTER		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification	
2. STATE VENDOR OR MEDICAL (L2) 955270700	D NO.	(L4) 1412 WEST (L5) RED WING		REET	(L6) 55066	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other	
5. EFFECTIVE DATE CHANGE OF (L9)	FOWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint	
6. DATE OF SURVEY 10 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/25/2017 ^(L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30	
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	IS CERTIFIED	AS:			
From (a): To (b):		Compliance	ance With equirements e Based On: acceptable POC		And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI	6. Scope of Services Limit 7. Medical Director	
12.Total Facility Beds	130 (L18)	1. A			4. 7-Day KN (Kutai SNI 5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	130 (L17)	X B. Not in Con Requirements	npliance with Prog and/or Applied W			(L12)	
14. LTC CERTIFIED BED BREAKD	OWN	Requirements	and/or Applied w	varvers.	* Code: A 15. FACILITY MEETS	(L12)	
18 SNF 18/19 SNI 130		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE Sandra Tatro, HFE		Date :	0/18/2017		18. STATE SURVEY AGENCY		
				(L19)		Enforcement Specialist 01/25/2018 (L20)	
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE ST	TATE AGENCY	
 DETERMINATION OF ELIGIB _X_ 1. Facility is Eligible to 2. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	I CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 		
22. ORIGINAL DATE						g 20)	
OF PARTICIPATION 11/01/1978	23. LTC AGREEN BEGINNINC		4. LTC AGREEM ENDING DAT		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure		
	(1.41)		(1.25)		02-Dissatisfaction W/ Reimburses	05-Fail to Meet Health/Safety ment 06-Fail to Meet Agreement	
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATT A. Suspension	VE SANCTIONS a of Admissions:	(L25)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	-	
(L27)	B. Rescind Su	spension Date:	(L44)			00-7 6476	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APPR	OVAL	



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 245223

January 25, 2018

Mr. Dennis Decosta, Administrator Red Wing Health Center 1412 West Fourth Street Red Wing, MN 55066

Dear Mr. Decosta:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 25, 2017 the above facility is certified for:

130 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 130 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

January 25, 2018

Mr. Dennis Decosta, Administrator Red Wing Health Center 1412 West Fourth Street Red Wing, MN 55066

RE: Project Number S5223027

Dear Mr. Decosta:

On October 3, 2017 and October 17, 2017, we informed you that the following enforcement remedies were being imposed:

• State Monitoring effective October 22, 2017. (42 CFR 488.422)

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 28, 2017. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on July 28, 2017, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 28, 2017. The most serious deficiencies at the time of the revisit were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 25, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on September 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 25, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on September 28, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 25, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letters of October 3, 2017 and October 17, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 28, 2017, be rescinded. (42 CFR 488.417 (b))

Red Wing Health Center January 25, 2018 Page 2

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 28, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 28, 2017, is to be rescinded.

In our letter of October 3, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 28, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 25, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kumala Piske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File



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Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

December 19, 2017

Dennis Decosta, Administrator Red Wing Health Center 1412 West Fourth Street Red Wing, MN 55066

RE: Project Number S5223027

Dear Mr. Decosta:

On October 25, 2017, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on October 25, 2017, imposed a daily fine in the amount of \$300.00.

On October 25, 2017, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on October 25, 2017 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is \$300.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$208.80, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$508.80 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Red Wing Health Center December 19, 2017 Page 2 Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

DEPARTMENT OF HEAI	TH AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: 5Z1K		
	PART I -	TO BE COMP	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00149		
1. MEDICARE/MEDICAID PROV NO.(L1) 245223	IDER	3. NAME AND AI (L3) RED WING	HEALTH CEN	NTER		 TYPE OF ACTION: <u>7</u>(L8) Initial Recertification 		
2. STATE VENDOR OR MEDICA (L2) 955270700	AID NO.	(L4) 1412 WEST (L5) RED WING		REET	(L6) 55066	3. Termination 4. CHOW 5. Validation 6. Complaint 7. O. Str. Visit 0. Out		
5. EFFECTIVE DATE CHANGE O	OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY	<u>02</u> (L7)	7. On-Site Visit 9. Other		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint		
	28/2017 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X Pay	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distillet	07 X-Ray 08 OPT/SP	12 RHC	16 HOSPICE	09/30		
2 AOA 3 Othe		04 5111	00 01 1/51	12 KIC	10 HOST ICE			
11LTC PERIOD OF CERTIFICAT	ION	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of 7	The Following Requirements:		
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit		
		Complianc	e Based On:		3. 24 Hour RN	7. Medical Director		
12 Total Facility Dada	120 (118)	1. A	cceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Size		
12. Total Facility Beds	130 (L18) 130 (L17)	V. D. Maria			5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	150 (L17)	X B. Not in Con Requirements	and/or Applied W		* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAK	DOWN				15. FACILITY MEETS			
18 SNF 18/19 SN	IF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
130								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE	EMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION L	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Sandra Tatro, HFE	NE II	1	0/18/2017	(110)	Kamala Fiske-Downing, I	Enforcement Specialist 12/29/2017		
ŋ	ART II - TO BE	COMPLETED I	RV HCFA PF	(L19)	AL OFFICE OR SINGLE STATE AGENCY			
19. DETERMINATION OF ELIGI	BILITY		IPLIANCE WITH HTS ACT:	ICIVIL		icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)		
X 1. Facility is Eligible	to Participate				3. Both of the Above			
 Facility is not Elig 								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	J DATE	ENDING DAT	ΤE	VOLUNTARY 00	INVOLUNTARY		
11/01/1978					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	n OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
			(L44)			00-Active		
(L27)	B. Rescind St	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APPR	ROVAL		



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

October 17, 2017

Mr. Dennis Decosta, Administrator Red Wing Health Center 1412 West Fourth Street Red Wing, MN 55066

RE: Project Number S5223027

Dear Mr. Decosta:

On August 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 28, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 28, 2017, the Minnesota Department of Health and on September 11, 2017, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 11, 2017. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 28, 2017. The deficiencies not corrected are as follows:

F431 -- S/S: E -- 483.45(b)(2)(3)(g)(h) -- Drug Records, Label/Store Drugs & Biologicals F441 -- S/S: D -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective October 22, 2017. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last

day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 28, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 28, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 28, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Red Wing Health Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective October 28, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

> Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor Rochester Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: gary.nederhoff@state.mn.us Phone: (507) 206-2731 Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 28, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	`́сом	E SURVEY IPLETED
		245223	B. WING				R 28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ſS	{F 00)0}			
{F 431} SS=D	completed on Septe certification tags that found on the CMS2 that were not found PCR which are loca Because you are en- signature is not req page of the CMS-23 submission of the F verification of comp Upon receipt of an on-site revisit of you validate that substar regulations has bee your verification. 483.45(b)(2)(3)(g)(f LABEL/STORE DR The facility must pro- drugs and biological them under an agre §483.70(g) of this p unlicensed personn law permits, but on supervision of a lice (a) Procedures. A f pharmaceutical ser that assure the acc dispensing, and add biologicals) to meet	Aliance. acceptable electronic POC, an ur facility will be conducted to ntial compliance with the en attained in accordance with n) DRUG RECORDS, UGS & BIOLOGICALS ovide routine and emergency als to its residents, or obtain element described in art. The facility may permit tel to administer drugs if State y under the general ensed nurse. facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. ation. The facility must e services of a licensed	{F 43	31}			10/20/17
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						10/17/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 10/18/2017

		AND HUMAN SERVICES				FORM	10/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245223	B. WING				२ 28/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 431}	Continued From pa pharmacist who	ge 1	{F 4	31}			
	disposition of all co	ystem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and					
	that an account of a	t drug records are in order and all controlled drugs is riodically reconciled.					
	labeled in accordan professional princip appropriate access	als used in the facility must be nee with currently accepted bles, and include the					
	the facility must sto locked compartmer	with State and Federal laws, ire all drugs and biologicals in ints under proper temperature it only authorized personnel to					
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected. This REQUIREMEN by:	NT is not met as evidenced					
	review, the facility facility facility	tion, interview and document ailed to dispose of expired and cations in 2 of 5 medication			F 431 Storage of Medication Immediate corrective action: The Humalog Insulin and Air Life		

Facility ID: 00149

If continuation sheet Page 2 of 10

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED
		0.45000				R
		245223	B. WING		09/	28/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
{F 431}	Continued From pa	ae 2	{F 43	1}		
. ,	carts affecting resid facility stock supply Findings include:	lents (R92,R70, R94) and		Modudose identified was discar Action as it applies to others: Medication will be checked as p medication administration policy procedure to assure when med are opened they are labeled; to	oart of the / and ications	
	On 9/27/17, at 9:15 a.m., a medication storage cart on 3 west was checked with licensed practical nurse (LPN)-D. An unsealed bottle of Humalog insulin, labeled for administration to R92, was observed to have a manufacturer's expiration date of 8/25/17. LPN-D stated that R92 had received this medication from this bottle yesterday. LPN-D reviewed the resident's Medication Adminstation Record (MAR) and stated this medication had been given in varying, small doses up to three times per day through-out		dates are current and any outda medication will be destroyed per medication destruction policy. All licensed nurses were in-serve the process of dating medication opened and checking medication carts/rooms/refrigerators for ex medications each shift during the medication passes as part of the	ated r viced on ns when on pired heir		
	the prior week, as c even though it had On 9/27/17, at 9:18 storage cart was ch nurse (LPN)-A. Mee were checked for e bottles were opener she checks expirati medications and re	ordered by R92's physician expired on 8/25/17. a.m. 2 west (2W) medication necked with licensed practical dication bottles and cards xpiration dates and dates d if needed. LPN-A stated that on dates when she dispenses		medication pass routine. Date of completion:10/20/20 Recurrence will be prevented b All medication carts/rooms/refr will be audited 1x weekly for da medications when opened, prop labeling, and for expired meds. will continue x60 days and resu with the facility QAPI monthly for the need to increase, decrease discontinue the audits.	y: igerators ting ber This audit Its shared or input on	
	of Probiotic 10 labe had a label to keep she had checked a discontinued for R7 why the medication second medication LPN-B and there w did not have a phar insulin pen indicate In addition, there w across the insulin p	led for R70. One of the bottles it refrigerated. LPN-A stated nd the Probiotic had been '0 and said she did not know was still on the cart. The cart on 2W was checked with as a Humalog Flex Pen that macy label on it. The date the d it had been opened 6/11/17. as a piece of white tape en with the first name and last vritten on it, and there was a		The correction will be monitored DON/Designee	d by:	

If continuation sheet Page 3 of 10

		AND HUMAN SERVICES				FORM	10/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245223	B. WING				२ 28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	IG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 431}	box with 11 individu Life Modudose 0.9% saline solution to he an expiration date of the vials were used breathing treatment change medication inhaling by the resid not know if the solur resident's nebulizer the insulin pen LPN think R94 was curre insulin. LPN-A was long to keep an ope LPN-A stated there laminated sheet on number of days it w drops, nasal sprays However LPN-A act one of those sheets The medication adr May 2017, through were reviewed. It w been administered days after the expir Medication Storage revised on January discontinued, outda medications/solutio facility. All such me destroyed."	al dose vials containing Air % sodium chloride solution (a elp improving breathing) with of July 2015. LPN-B stated that for mixing a nebulizer (a t that uses a machine to solution into a mist for dent). LPN-B stated she did tion had been used for any treatment. When asked about I-B stated that she did not ently receiving that form of asked how she knew how en container insulin in use was supposed to be a the medication cart with the vas acceptable to keep eye s, and insulin after opened. knowledged she had not seen s yet. ministration record (MAR) from September 2017, for R94 vas noted Humalog insulin had to R94 once on 8/16/17, 35 ation date of 7/12/17.	{F 4	31}			

Facility ID: 00149

If continuation sheet Page 4 of 10

		AND HUMAN SERVICES				FORM	: 10/18/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED
		245223	B. WING	i			R 28/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 441} SS=D		e)(f) INFECTION CONTROL, D, LINENS	{F 4	41]	}		10/20/17
	(a) Infection preven	tion and control program.					
		tablish an infection prevention n (IPCP) that must include, at owing elements:					
	investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin	d upon the facility assessment ng to §483.70(e) and following standards (facility assessment					
		ds, policies, and procedures nich must include, but are not					
	possible communic	eillance designed to identify able diseases or infections read to other persons in the					
		nom possible incidents of ease or infections should be					
		ansmission-based precautions event spread of infections;					
	(iv) When and how resident; including b	isolation should be used for a but not limited to:					
		uration of the isolation, e infectious agent or organism					

If continuation sheet Page 5 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMI	E SURVEY PLETED
		245223	B. WING				२ 28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	G HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
{F 441}	least restrictive pos circumstances. (v) The circumstance must prohibit emploid disease or infected contact with resider contact will transmit (vi) The hand hygie by staff involved in or (4) A system for recu under the facility's I actions taken by the (e) Linens. Person process, and transp spread of infection. (f) Annual review. annual review of its program, as necess This REQUIREMEN by: Based on observat review, the facility fa hygiene and gloving the spread of infect R84) observed for p treatment. Findings include: R70's admission re	hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct the disease; and ne procedures to be followed direct resident contact. Fording incidents identified PCP and the corrective e facility. nel must handle, store, bort linens so as to prevent the The facility will conduct an IPCP and update their sary. NT is not met as evidenced ion, interview and document ailed to ensure proper hand g were performed to prevent ion for 2 of 4 residents (R70, berineal care and wound	{F 44	41}	F 441 Infection Control Immediate corrective action: NAR A, B, and C were re-educated handwashing/glove use policy and competencies completed on 10/18/1 LPN A was re-educated on handwas policy and competency was complet 9/29/17. Action as it applies to others:	17. shing	
	current diagnoses of	cord dated 9/29/17, indicated of quadriplegia, urinary tract ry of methicillin resistant			Action as it applies to others: The Policies and Procedures for handwashing and glove use change	9	

Facility ID: 00149

If continuation sheet Page 6 of 10

PRINTED: 10/18/2017

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	`´co∧	E SURVEY IPLETED
		245223	B. WING			R 28/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	20/2011
	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
{F 441}	staphylococcus aur documentation for F R70 had a left lowe that was length 5.5 unstageable, clean Optifoam, change on needed). On 9/28/17, at 9:49 cares, nursing assist door and entered the wash hands then do to wash R70's face basin with water the towel. NA-C knocket washed hands and continued cares and under arms with we arms with dry towel R70's under arms. R70's t-shirt. With F NA-B took R70's in provided peri care. gloves placed hand resident on right sic right side, NA-C wip disposable wipes. N	ge 6 eus infection. Weekly wound R70 dated 9/4/17, indicated r leg (rear) pressure wound, centimeter (cm) by width 4 cm apply Santyl cover with q (every) day and prn (as a.m., during R70's morning stant (NA)-B knocked on the he room. NA-B observed to onned gloves and proceeded with wet wash cloth from a en dried R70's face with dry ed and entered R70's room, donned gloves. NA-B d washed R70's bilateral et wash cloth then dried under . NA-C then put deodorant on NA- B and NA-C donned R70's head of bed lowered flat, continence brief off and NA-B with the same soiled ls on R70's body to turn de. While R70 was laying on oed R70's buttock's area with NA-C confirmed R70 had a hen R70's incontinence brief	{F 44	 remain current. All nursing staff have been educa handwashing and glove use. Date of completion:10/20/2017. Recurrence will be prevented by: Visual audits of handwashing pra when indicated, to include proper as well as hand washing and glo changing will be conducted 2x we days on various Units. Results w shared with and evaluated by the QAPI committee for input on the increase, decrease or discontinu audits. The correction will be monitored DON/Designee 	ictices barriers ve eekly x30 vill be facility need to e the	
	clean incontinence removed soiled glov wash their hands. N R70's, shorts were on both feet. Then the positioned under R water out of basin.	hold on to R70 to put on brief. NA-B and NA-C both ves and did not immediately IA-B and NA-C continued with put on along with soft booties the mechanical lift sling was 70's body. NA-B dumped NA-C put dirty lines in clear long with NA-C then washed				

If continuation sheet Page 7 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/18/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245223	B. WING				R 28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	IG HEALTH CENTER				412 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 441}	Continued From pa	ge 7	{F 4	41}			
	NA-C stated, "I sho after cleaning his be after putting his sho would be the expect stated that should v care and when you During an interview when asked NA-B a expectations she st	on 9/28/17 at 10:39 a.m., about hand hygiene ated when you walk into the					
	stated when asked	thing dirty like pericare. NA-B if she washed hands after peri stated she did not do it right					
	(DON) on 9/28/17 a expectations for ha policy and procedur handsanitizer or ha	nd hygiene would be to follow e, staff should use ndwashing when removing es or hands are soiled staff					
	9/28/17 at 11:02 a.r (LPN)-A, came in R then donned gloves R70's left calf, dres circle brown drainag then set dressing o normal saline on ga then wiped wound w on bare mattress w gloves on grabbed dry, put dry gauze o gloves on LPN-A pi	ion of a dressing change on n., licensed practical nurse 70's room and washed hands 5. LPN-A removed dressing on sing had small amount of half ge, LPN-A folded dressing, n bare mattress, placed auze with same gloves on, with wet gauze, placed gauze ith dressing, with the same another gauze patted wound on bare mattress, with same cked up tube of Santyl put it nd, stated wound had more					

Facility ID: 00149

If continuation sheet Page 8 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245223	B. WING				२ 28/2017
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	granulation tissue a around wound. LPN calf then dated dress gloves and washed gloves. LPN-A obset suprapubic site. At and came into R70' donned gloves. LPN connection with alco catheter line as LPN clear liquid towards on gauze, wiped su and placed a split g LPN-A put tape on 1 dressing. LPN-A too her hands and left t resident position an room. During an interview asked LPN-A if she dressing was remove change, LPN-A veri gloves. R84 had been obset after nursing assists washing his hands R84 stated he was NA-A went out of roo linens for the bed. Of the bedside table. N clean incontinence and removed the to placed it on the floo proceeded to loose wall side of the bed shoulder. NA-A ther brief R84 was wear	ge 8 Ind still getting eschar off J-A put on new dressing on left ssing. LPN-A then removed hands and donned new erved to take dressing off 11:08 a.m., NA-C knocked s room, washed hands then N-A cleaned the catheter ohol wipe. NA-C then held N-A flushed the line with a R70. LPN-A put normal saline prapubic site dry with gauze auze over suprapubic site. the split gauze and dated ok gloves off. NA-C washed he room. LPN-A adjusted id washed hands and left the on 9/28/17 at 1:34 p.m., when changed gloves after old ved during the dressing fied she did not change her erved on 9/27/17, at 1:52 p.m. ant (NA)-A was observed prior to going into R84's room. "soaked" through to the sheet. oom and came back with clean Clean linens were placed on VA-A gathered wipes and a brief, put on a pair of gloves ip sheet from the bed and or at the foot of the bed. NA-A in the bottom sheet from the and tucked under R84's in opened up the incontinence ing and began cleaning R84's A had R84 roll towards the	{F 4	41}			

If continuation sheet Page 9 of 10

		AND HUMAN SERVICES				FORM	10/18/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245223	B. WING	;			R 28/2017
NAME OF	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	NG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	 wall. NA-A then rem R84 was wearing, w several wipes, and then removed the b sheet from the bed at the foot of the bed at the foot of the bed NA-A took the clear sheet and put them R84 roll onto his ba putting the bottom s place on the bed. N top sheet. R84 india a clean top sheet of the remote control of down to lowest level gloves and went inth his hands. During an interview (DON) on 9/28/17 a expectations for ha change, was hands gloves are donned removed. The facility's hand w 2014, "Employees of least 20 seconds us non-antimicrobial so following conditions soiled (hand washin Before and after as personal care (e.g., and after changing 	wiped the incontinence brief wiped the rectal area with put a clean brief on R84. NA-A bottom sheet and the draw and placed them on the floor ed. Without changing gloves, in bottom sheet and clean draw a under R84. Then NA-A had ack again. NA-A finished sheet and draw sheet into IA-A asked R84 if he wanted a icated that he did so NA-A put ver R84. NA-A then picked up for the bed and lowered bed el. NA-A then removed his to the bathroom and washed with Director of Nursing at 2:17 p.m., DON's ind hygiene during dressing is should be washed when and after soiled dressing was washing policy dated October must wash their hands for at sing antimicrobial or oap and water under the is: b. When hands are visibly ing with soap and water); h. issisting a resident with , oral care, bathing); k. Before a dressing; f. After handling is, dressings, bedpans,	{F 4	41}			

Facility ID: 00149

If continuation sheet Page 10 of 10



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on XXXXXXX.

October 17, 2017

Mr. Dennis Decosta, Administrator Red Wing Health Center 1412 West Fourth Street Red Wing, MN 55066

Re: Project Number S5223027

Dear Mr. Decosta:

On September 28, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 28, 2017 with orders received by you electronically on August 11, 2017.

State licensing orders issued pursuant to the last survey completed on July 28, 2017, found not corrected at the time of this September 28, 2017 revisit and subject to penalty assessment are as follows:

21375 -- MN Rule 4658.0800 Subp. 1 -- Infection Control; Program - \$300.00

The details of the violations noted at the time of this revisit completed on September 28, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, Po Box 64900 St Paul MN 55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be

conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

Minnesota Department of Health								
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		00149	B. WING		F 09/2	R 8/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-			
	IG HEALTH CENTER		G, MN 5506					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE		
{2 000}	Initial Comments		{2 000}					
	*****ATTE	NTION*****						
	NH LICENSING	CORRECTION ORDER						
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall I with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been						
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.						
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at ate.mn.us/divs/fpc/profinfo/inf elicensing orders are						
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE		

Electronically Signed

10/17/17

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If continuation sheet 1 of 7

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00149	B. WING			R 2 8/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{2 000}	Continued From pa	-	{2 000}			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				
	Department's staff the following correct be corrected. Pleat plan of correction the	28, 2017, surveyors of this visited the above provider and ction orders were not found to se indicate in your electronic hat you have reviewed these the date when they will be				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled " II statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
nnosota D	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

Minnesc	ta Department of He	ealth			IAPPROVEI
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		00149	B. WING	R 9/28/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	IG HEALTH CENTER	1412 WES	ST FOURTH	STREET	
		RED WIN	G, MN 5506	6	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From pa	ige 2	{2 000}		
		R ON EACH PAGE.			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
{21375}	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	{21375}		10/20/17
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.			
	by: "Uncorrected based original licensing or will remain in effect recommended." Based on observati review, the facility f hygiene and gloving the spread of infect R84) observed for p treatment. Findings include: R70's admission re current diagnoses of infections and histor staphylococcus aur documentation for l R70 had a left lowe	ent is not met as evidenced d on the following findings. The order issued on July 28, 2017, the Penalty assessment ion, interview and document ailed to ensure proper hand g were performed to prevent tion for 2 of 4 residents (R70, perineal care and wound cord dated 9/29/17, indicated of quadriplegia, urinary tract ory of methicillin resistant reus infection. Weekly wound R70 dated 9/4/17, indicated or leg (rear) pressure wound, centimeter (cm) by width 4 cm		F 441 Infection Control Immediate corrective action: NAR A, B, and C were re-educated and handwashing/glove use policy and competencies completed on 10/18/17(date). LPN A was re-educated on handwashing policy and competency was completed on 9/29/17. Action as it applies to others: The Policies and Procedures for handwashing and glove use change remain current. All nursing staff have been educated for handwashing and glove use. Date of completion:10/20/2017 Recurrence will be prevented by: Visual audits of handwashing practices when indicated, to include proper barriers as well as hand washing and glove	

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If continuation sheet 3 of 7

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00149	B. WING			२ 28/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE			
RED WII	NG HEALTH CENTER		ST FOURTH IG, MN 5506				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BY FULL PREFIX (EACH DEFIC		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{21375}	Continued From pa	ge 3	{21375}				
	Optifoam, change on needed). On 9/28/17, at 9:49 cares, nursing assist door and entered the wash hands then do to wash R70's face basin with water the towel. NA-C knocked washed hands and continued cares an under arms with dry towel R70's under arms. R70's t-shirt. With F NA-B took R70's im- provided peri care. gloves placed hand resident on right side right side, NA-C wind disposable wipes. N bowel movement the was tucked under. NA-C proceeded to clean incontinence removed soiled glow wash their hands. N R70's, shorts were on both feet. Then positioned under R water out of basin. plastic bag. NA-B a hands. During an interview NA-C stated, "I sho	a, (every) day and prn (as a.m., during R70's morning stant (NA)-B knocked on the be room. NA-B observed to onned gloves and proceeded with wet wash cloth from a en dried R70's face with dry ed and entered R70's room, donned gloves. NA-B d washed R70's bilateral et wash cloth then dried under . NA-C then put deodorant on NA-B and NA-C donned R70's head of bed lowered flat, continence brief off and NA-B with the same soiled is on R70's body to turn de. While R70 was laying on bed R70's buttock's area with VA-C confirmed R70 had a nen R70's incontinence brief R70 was rolled on back and hold on to R70 to put on brief. NA-B and NA-C both ves and did not immediately VA-B and NA-C continued with put on along with soft booties the mechanical lift sling was 70's body. NA-B dumped NA-C put dirty lines in clear long with NA-C then washed		days on various Units. Re shared with and evaluated QAPI committee for input increase, decrease or dis- audits. The correction will be mor DON/Designee	d by the facility on the need to continue the		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00149			CONSTRUCTION	COMF	E SURVEY PLETED
			B. WING			28/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		ST FOURTH S IG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
{21375}	Continued From pa	ge 4	{21375}			
	•	vash hands anything after peri				
	when asked NA-B a expectations she st room and after any stated when asked care with R70 she s after peri care. During an interview	ated when you walk into the thing dirty like pericare. NA-B if she washed hands after per stated she did not do it right with Director of Nursing				
	policy and procedur handsanitizer or ha	nd hygiene would be to follow re, staff should use ndwashing when removing es or hands are soiled staff				
	9/28/17 at 11:02 a.r (LPN)-A, came in R then donned gloves R70's left calf, dres circle brown drainag then set dressing o normal saline on ga then wiped wound	ion of a dressing change on m., licensed practical nurse 70's room and washed hands s. LPN-A removed dressing on sing had small amount of half ge, LPN-A folded dressing, n bare mattress, placed auze with same gloves on, with wet gauze, placed gauze ith dressing, with the same				
	dry, put dry gauze of gloves on LPN-A pi over eschar of wou granulation tissue a around wound. LPN calf then dated dres gloves and washed	another gauze patted wound on bare mattress, with same cked up tube of Santyl put it nd, stated wound had more and still getting eschar off I-A put on new dressing on left ssing. LPN-A then removed hands and donned new erved to take dressing off	t			
	suprapubic site. At	11:08 a.m., NA-C knocked 's room, washed hands then				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:			СОМ	E SURVEY PLETED
		00149	B. WING			28/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	NG HEALTH CENTER		ST FOURTH S G, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
{21375}	donned gloves. LPN connection with alco catheter line as LPN clear liquid towards on gauze, wiped su and placed a split g LPN-A put tape on the dressing. LPN-A too her hands and left the resident position and room. During an interview asked LPN-A if she dressing was remote change, LPN-A verify gloves. R84 had been obset after nursing assists washing his hands R84 stated he was NA-A went out of roo linens for the bed. Of the bedside table. Not clean incontinence and removed the to placed it on the floo proceeded to loose wall side of the bed shoulder. NA-A ther brief R84 was wear front peri area. NA-	N-A cleaned the catheter ohol wipe. NA-C then held N-A flushed the line with a R70. LPN-A put normal saline prapubic site dry with gauze auze over suprapubic site. the split gauze and dated ok gloves off. NA-C washed he room. LPN-A adjusted d washed hands and left the on 9/28/17 at 1:34 p.m., when changed gloves after old ved during the dressing fied she did not change her erved on 9/27/17, at 1:52 p.m. ant (NA)-A was observed prior to going into R84's room. "soaked" through to the sheet. om and came back with clean Clean linens were placed on VA-A gathered wipes and a brief, put on a pair of gloves p sheet from the bed and ir at the foot of the bed. NA-A in the bottom sheet from the and tucked under R84's in opened up the incontinence ing and began cleaning R84's A had R84 roll towards the			.,	
	R84 was wearing, v several wipes, and then removed the b sheet from the bed at the foot of the be	noved the incontinence brief viped the rectal area with put a clean brief on R84. NA-A ottom sheet and the draw and placed them on the floor d. Without changing gloves, n bottom sheet and clean draw				

PRINTED: 10/18/2017 FORM APPROVED

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R	
00149		B. WING		09/2	28/2017	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
	IG HEALTH CENTER		ST FOURTH S NG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
[21375]	Continued From pa	0	{21375}			
	R84 roll onto his ba putting the bottom s place on the bed. N top sheet. R84 indi a clean top sheet o the remote control t down to lowest leve gloves and went int his hands.	a under R84. Then NA-A had ack again. NA-A finished sheet and draw sheet into IA-A asked R84 if he wanted a icated that he did so NA-A put ver R84. NA-A then picked up for the bed and lowered bed el. NA-A then removed his to the bathroom and washed				
	(DON) on 9/28/17 a expectations for ha change, was hands	with Director of Nursing at 2:17 p.m., DON's nd hygiene during dressing s should be washed when and after soiled dressing was				
	2014, "Employees in least 20 seconds us non-antimicrobial se following conditions soiled (hand washin Before and after as personal care (e.g., and after changing	washing policy dated October must wash their hands for at sing antimicrobial or oap and water under the s: b. When hands are visibly ng with soap and water); h. sisting a resident with , oral care, bathing); k. Before a dressing; f. After handling hs, dressings, bedpans, ls."				

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

 \cap 2

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On October 25, 2017,
I, <u>Dennis De Costa</u> (Name)(Please Print) <u>(Title)(Please Print)</u> , received the Notice of Penalty Assessment dated October 25, 2017, and licensing orders issued to:
Red Wing Health Center 1412 West Fourth Street Red Wing, MN 55066
The Penalty Assessments and licensing orders attached hereto have been corrected as of October 25, 2017.
Signed: Dennis De Casta, Administratol, Date 10125(17 (Name)(Please Print) (Title)(Please Print)
DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE
On October 25, 2017,
1, Vicky Hamensma, Nurse Evaluator If of the Health Regulation Division,
(Name)(Please Print) (Title)(Please Print) Minnesota Department of Health, delivered the Notice of Penalty Assessment dated and issued to:
Red Wing Health Center 1412 West Fourth Street Red Wing, MN 55066
The Notice of Penalty Assessment was handed to $\underbrace{Vickic Holtz}_{(Name)(Please Print)}$, Date $\underbrace{10-35117}_{(Title)(Please Print)}$
Signed:

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MED	ICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 5Z1K
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00149
1. MEDICARE/MEDICAID PROVID (L1) 245223	ER NO.	3. NAME AND ADDRESS OF FACILITY (L3) RED WING HEALTH CENTER				 TYPE OF ACTION: <u>2</u>(L8) Initial 2. Recertification
2.STATE VENDOR OR MEDICAID (L2) 955270700	(L4) 1412 WEST FOURTH STREET (L5) RED WING, MN		(L6) 55066	3. Termination4. CHOW5. Validation6. Complaint		
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 07/24 8. ACCREDITATION STATUS: 0 Unaccredited 0 Unaccredited 1 TJC 2 AOA 3 Other	8/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
 11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 	N 130 (L18) 130 (L17)	Compliance 1. A X B. Not in Con	nnce With equirements e Based On: cceptable POC	gram	And/Or Approved Waivers Of 7 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B *	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDO	OWN	1	11		15. FACILITY MEETS	
18 SNF 18/19 SNF 130	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE	E NE II	Date : 0	08/22/2017		18. STATE SURVEY AGENCY	APPROVAL Date: Enforcement Specialist 10/03/2017
DA	рт II – то ре /	COMDI ETED I	DV LICEA DE	(L19)	OFFICE OR SINGLE S	(L20)
19. DETERMINATION OF ELIGIBII 1. Facility is Eligible to I 2. Facility is not Eligible	LITY Participate	20. COM	IPLIANCE WITH ITS ACT:		21. 1. Statement of Finan	cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 11/01/1978	BEGINNINC		ENDING DA		VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	··· · ··· ··· ··· ··· ··· ··· ··· ···
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active
(L27)	B. Rescind St	spension Date:	. ,			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APPE	ROVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 11, 2017

Mr. Dennis Decosta, Administrator Red Wing Health Center 1412 West Fourth Street Red Wing, MN 55066

RE: Project Number S5223027

Dear Mr. Decosta:

On July 28, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor Rochester Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: gary.nederhoff@state.mn.us Phone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 6, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 6, 2017 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

Red Wing Health Center August 11, 2017 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 28, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

Red Wing Health Center August 11, 2017 Page 5

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 28, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Red Wing Health Center August 11, 2017 Page 6

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		245223	B. WING		07	/28/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	0		
F 225 SS=D	as your allegation of Department's accep enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substa regulations has bee your verification. 483.12(a)(3)(4)(c)(7 ALLEGATIONS/INE 483.12(a) The facilit (3) Not employ or of who- (i) Have been found exploitation, misapp mistreatment by a c (ii) Have had a find nurse aide registry exploitation, mistreat misappropriation of (iii) Have a disciplin or her professional body as a result of	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with 1)-(4) INVESTIGATE/REPORT DIVIDUALS ity must- therwise engage individuals d guilty of abuse, neglect, propriation of property, or court of law; ing entered into the State concerning abuse, neglect, atment of residents or their property; or hary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or	F 22	5		8/31/17
	(4) Report to the St	ate nurse aide registry or				
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					08/21/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/21/2017

		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/2	28/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	NG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	licensing authorities actions by a court of which would indicate nurse aide or other (c) In response to a exploitation, or mist (1) Ensure that all a abuse, neglect, explicitly including injuries of misappropriation of reported immediate after the allegation cause the allegation cause the allegation serious bodily injury the events that caus abuse and do not re the administrator of officials (including to adult protective ser- for jurisdiction in lor accordance with Sta- procedures. (2) Have evidence to thoroughly investigation (3) Prevent further presentative and with State law, inclu- Agency, within 5 wor	s any knowledge it has of of law against an employee, te unfitness for service as a facility staff. Allegations of abuse, neglect, treatment, the facility must: alleged violations involving ploitation or mistreatment, f unknown source and f resident property, are ely, but not later than 2 hours is made, if the events that in involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other o the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established that all alleged violations are ated. potential abuse, neglect, treatment while the rogress.	F 2	225			

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI	TIPI	E CONSTRUCTION	MB NO.	E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		245223	B. WING			07/2	28/2017	
IAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	IG HEALTH CENTER		1412 WEST FOURTH STREET RED WING, MN 55066					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 225	Continued From pa	ge 2	F 2	225				
	corrective action m	-						
		tion, interview and document			F 225			
	review, the facility facility facility	ailed to immediately report an			Immediate corrective action:			
		emotional abuse to the State			LPN A was educated on 7/26/2017	on the		
		of Health Facility Complaints)			need to administer resident 104			
	for 1 of 4 residents	(R104) reviewed for abuse.			medications in a public place and a have a witness present when in res			
	Findings include:				104 room due to history of false accusations against staff. The alle			
	R104 on 7/26/17. a	t 8:10 a.m. was noted sitting in			against LPN A of being rude and be			
		04 called this surveyor over			scared of her made by resident 104			
		ed practical nurse (LPN)-A "is			reported to OHFC on 7/27/2017.			
		am literally afraid of her, she			Action as it applies to others:			
		and a lot of tension in the air R104 indicated this is an			The Policy and Procedure for Abus Prevention was reviewed and remain			
		her. According to R104 this			current.	anno		
		reported to the Director of			Immediate education was begun for	or all		
		re. When R104 reported this			staff on the Abuse Prevention Polic	;у		
	allegation of abuse	she was crying.			which includes timely reporting to			
	Op 7/26/17 at 8:30	a.m. two surveyors reported			supervisor and State reporting time including immediate reporting for	elines,		
		f emotional abuse to the			allegations of abuse.			
		(DON). The DON explained to			Date of completion:			
		he situation for R104 was			8/31/17			
		e resident targeting LPN-A.			Recurrence will be prevented by:			
		s related to her behavior as networking to her beta not cuddly."			All resident incidents are reviewed day and pm at Quality Conference			
		ipetent but not educity.			Quality Wrap up to assure timely	anu		
	On 7/26/17, at 9:04	a.m. R104 called this			reporting, investigation and follow-u	up.		
		l, "Are you sure nothing going			These incidents are discussed eac			
		Surveyor reassured resident			month at QAPI and this process wi	11		
		any retaliation for reporting use. At 9:10 a.m. DON stated,			continue ongoing. The correction will be monitored by	<i>.</i>		
		you know we take abuse			Administrator/Designee			
	allegations serious	y." The DON continued						
		4 has reported to staff of						
	allegation of abuse	against LPN-A in the past and						

		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/:	28/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
	IG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	the facility educated educated to give R ² place or have anoth immediate area. At reported R104 appr and said, "Guess I at talk to her [DON], d mad?" Resident way given the allegation reported to surveyo a.m. same day. On 7/27/17, at 8:44 DON and asked fol allegation of emotion asked if she had re to the designated si indicated she had re to the designated si report allegations o do not care if the re allegation to abuse next day after R104 Also the allegation of abuse next day after R104 Also the allegation for the designated si indicated she had re to find the offic (OHFC) which is the (SA). SSD then stated	d the nurse. LPN-A was 104's medication in a public her staff present in the 9:30 a.m. another surveyor roached her a few minutes ago am kind of anxious, did you lid you use my name? was she as reassured the DON was of abuse which R104 had or during an interview at 8:10 • a.m. surveyor met with the low up question about R104's onal abuse. The DON was ported the allegation of abuse tate agency. The DON not reported the allegation of 04 was making false LPN-A. • with the social service 2:26 p.m. in regards to when to f abuse/neglect, SSD stated, "I esident has 30 cases of staff or abuse we still have to natter, we are not the jury we On asking SSD if she was tion of abuse reported to the 8:30 a.m. regarding R104's	F 2	225			

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		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/:	28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET EED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225 F 226 SS=D	morning at 9:45 a.m During an interview administrator indica report such abuse a SA. The facility policy tit PLAN - MN dated N administrator is ultir prohibition plan and alleged or substanti neglect, or maltreat state agency must a " 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES 483.12 (b) The facility must written policies and (1) Prohibit and pre exploitation of resid resident property, (2) Establish policie investigate any such (3) Include training §483.95 (c) Abuse, neglect, the freedom from al requirements in § 4	n. a on 7/28/17, at 9:54 a.m. the ated his expectation was to allegation immediately to the the ABUSE PREVENTION Nov 2016 indicated, " The mately in charge of the abuse d must be informed of all iated incident of abuse, timent immediately The also be notified immediately 33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC t develop and implement procedures that: event abuse, neglect, and lents and misappropriation of es and procedures to h allegations, and as required at paragraph and exploitation. In addition to buse, neglect, and exploitation as.12, facilities must also	F 2				8/31/17
F 226	morning at 9:45 a.m During an interview administrator indica report such abuse a SA. The facility policy tit PLAN - MN dated N administrator is ultir prohibition plan and alleged or substanti neglect, or maltreat state agency must a " 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES 483.12 (b) The facility must written policies and (1) Prohibit and pre exploitation of resid resident property, (2) Establish policie investigate any such (3) Include training §483.95 (c) Abuse, neglect, the freedom from al requirements in § 4	n. a on 7/28/17, at 9:54 a.m. the ated his expectation was to allegation immediately to the the ABUSE PREVENTION Nov 2016 indicated, " The mately in charge of the abuse d must be informed of all iated incident of abuse, timent immediately The also be notified immediately 33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC t develop and implement procedures that: event abuse, neglect, and lents and misappropriation of es and procedures to h allegations, and as required at paragraph and exploitation. In addition to buse, neglect, and exploitation					8/31/1

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			X3) DATE	E SURVEY PLETED
		245223	B. WING	;		07/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	exploitation, and mi property as set forth (c)(2) Procedures for neglect, exploitation resident property (c)(3) Dementia ma prevention. This REQUIREMEN by: Based on observat review, the facility fa Prevention Plan reg reporting of an incid abuse to the State A Facility Compliance reviewed for abuse Findings include: The facility policy tit PLAN - MN dated N administrator is ultin prohibition plan and alleged or substant neglect, or maltreat	constitute abuse, neglect, sappropriation of resident at § 483.12. or reporting incidents of abuse, a, or the misappropriation of nagement and resident abuse NT is not met as evidenced ion, interview and document ailed to follow their Abuse parding the immediate lent of alleged emotional Agency (SA)(Office of Health) for 1 of 4 residents (R104)	F	220		ed on o a on re was e from o ns all	
	the dining room. R1 and reported licens so rude to me and I intimidates, scowls	t 8:10 a.m. was noted sitting in 04 called this surveyor over ed practical nurse (LPN)-A "is am literally afraid of her, she and a lot of tension in the air 2104 indicated this is			8/31/17 Recurrence will be prevented by: All resident incidents are reviewed ea day and pm at Quality Conference an Quality Wrap up to assure timely reporting, investigation and follow-up	nd	

Facility ID: 00149

If continuation sheet Page 6 of 65

						<u>). 0938-039</u>		
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED		
		245223	B. WING _		07	//28/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
RED WII	NG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE		
F 226	emotional abuse to situation has been Nurse (DON) befor her feeling, she wa surveyors went to t this emotional abus DON explained to t was ongoing with F targeting LPN-A. On 7/27/17, at 8:44 DON and asked fol allegation of emotio she had not report was making false a During an interview director (SSD) at 12 if the resident has 3 staff or abuse we s matter, we are not SSD also explained day (7/27/17) the a was not reported to Complaint (OHFC) us to do the report During an interview administrator indica report such abuse a SA. During an interview stated RN-A should investigation and re- incident was noted was not reported to	age 6 her. According to R104 this reported to the Director of e. When R104 had reported s crying. At 8:30 a.m. two he DON office and reported se allegation to DON. The he two surveyors the situation R104. This resident was a.m. surveyor met with the low up question about R104 onal abuse. The DON indicated the allegation because R104 accusation against LPN-A. with the social service 2:26 p.m. stated, "I do not care 30 cases of allegations toward till have to report, it does not the jury we are the reporters." d she didn't know until the next llegation of emotional abuse o the Office of Health Facility . SSD stated, "The DON asked this morning at 9:45 a.m." o on 7/28/17, at 9:54 a.m. the ated his expectation was to allegation immediately to the or on 7/28/17 at 8:53 a.m. DON a have started the abuse eported it immediately. The on 7/6/17, at 6:18 p.m. and it o OHFC, DON or Administrator ng which did not follow our	F 22	These incidents are discuss month at QAPI and this pro- continue ongoing. The correction will be monit Administrator/Designee	cess will			

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CENTERS FOR MEDICARE & MEDICA	AN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDE	ER/SUPPLIER/CLIA CATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
	245223	B. WING			07/2	28/2017
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WING HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID SUMMARY STATEMENT OF D PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 F 226 Continued From page 7 reporting of abuse is immediate regulations. Facility Policy titled Abuse Prevent effective 2012, revision Novem Components of Abuse Prevent indicated procedure in place to violations and substantiated indi- immediately to the State of Mir all necessary corrective action results of the investigation. F 280 483.10(c)(2)(i-ii,iv,v)(3),483.210 SS=D PARTICIPATE PLANNING CAU 483.10 (c)(2) The right to participate in and implementation of his or he plan of care, including but not 1 (i) The right to participate in the including the right to identify ind be included in the planning pro- request meetings and the right revisions to the person-centered (ii) The right to participate in es- expected goals and outcomes amount, frequency, and duratic other factors related to the effer plan of care. (iv) The right to receive the ser included in the plan of care. (v) The right to see the care plar right to sign after significant ch of care. 	vention Plan, iber 2016, III, ion Plan: F. 1) o report all alleged cidents inesota and take depending on the (b)(2) RIGHT TO RE-REVISE CP the development er person-centered imited to: e planning process, dividuals or roles to cess, the right to to request ed plan of care. etablishing the of care, the type, on of care, and any ectiveness of the vices and/or items an, including the	F 2				8/31/17

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		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/2	28/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	NG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	 (c)(3) The facility shright to participate in shall support the replanning process m (i) Facilitate the incleresident representation (ii) Include an assess strengths and need (iii) Incorporate the cultural preferences 483.21 (b) Comprehensive (2) A comprehensive (2) A comprehensive (ii) Developed within the comprehensive (ii) Prepared by an includes but is not I (A) The attending p (B) A registered numerication (C) A number of for (E) To the extent preference for the resident in the resident i	 all inform the resident of the n his or her treatment and esident in this right. The nust lusion of the resident and/or ative. ssment of the resident's ls. resident's personal and s in developing goals of care. Care Plans ve care plan must be- 7 days after completion of assessment. interdisciplinary team, that imited to 	F2	280			

Facility ID: 00149

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI	TIPI		<u>NO. 0938-0</u> DATE SURVE		
	OF CORRECTION	IDENTIFICATION NUMBER:	· /			COMPLETED		
		245223	B. WING			07/28/2017		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE		
F 280	• • • • • • • • • • • • • • • • • • • •	-	F 2	80				
	and their resident re	e participation of the resident epresentative is determined he development of the n.						
	(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.							
	team after each ass comprehensive and assessments. This REQUIREMEN	evised by the interdisciplinary sessment, including both the d quarterly review NT is not met as evidenced						
	review, the facility fa was updated and or and prevent further	tion, interview and document ailed to ensure a plan of care r revised to promote healing ulcers from developing for 1) who developed two pressure hip area.			F280 Care Plans Immediate corrective action: The Care Plan for residents #23 was updated with the necessary information soon as the omission was identified. Action as it applies to others: The Policy and Procedure for creating a			
	R23 was admitted t according to facility R23 had diagnosis failure with hypoxia neurogenic bowel, r	to the facility on 7/14/16, Admission Record. that included acute respiratory , traumatic brain injury, neuromuscular dysfunction of es, according to facility			maintaining current Care Plans remains current. All licensed nurses will be in-serviced o updating/maintaining Care Plans on 8/31/17(date). All residents with skin issues will have	3		
	physician progress Facility identified R2 Data Set (MDS), 4/4 term memory proble decision making, to	note dated 7/25/17. 23 on the quarterly Minimum 4/17, to have short and long em, severely impaired tally dependent on two staff / living which included bed			their Care Plans reviewed to assure the information is current and accurate. Date of completion:8/31/17 Recurrence will be prevented by: 3 Care Plans will be selected from random Units weekly and audited by the			
	mobility, transfers, o hygiene, always inc pain unable to answ range of motion on	dressing, toileting and continent of bowel and bladder, ver, functional limitation in both sides, unstageable to slough or eschar, pressure			ID Team to assure they are accurate ar comprehensive. This practice will continue x90 days and results shared w the facility QAPI committee for input on the need to increase, decrease or	nd vith		

Facility ID: 00149

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI		ONSTRUCTION		0. 0938-039 TE SURVEY	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:					MPLETED	
		245223	B. WING			07	/28/2017	
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
	IG HEALTH CENTER				WEST FOURTH STREET WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 280	Continued From pa	age 10	F 280	0				
	ulcer not present o	n prior assessment, feeding		di	iscontinue the audits.			
	tube, tracheostomy	v, suctioning, oxygen.		T	he correction will be monitored	by:		
		d R23 on the annual MDS		N	urse Managers/MDS Coordina	itors		
		ie as 4/4/17 MDS, and was						
	identified with no pa							
		to have two pressure ulcers s positioned on the right hip,						
-		it of a large amount of urine						
	while laying on the							
		pressure ulcer indicated the						
	following:							
		an unstageable area on right						
		7/17) and is at risk for more						
		terventions included: pressure						
		on bed, treatments as ordered, rse practitioner if wound						
		mination care plan, turn and						
		2.5 hours assist of 2 staff,						
		and weekly with bathing.						
	Care plan problem	of always incontinent of						
		r. Interventions included:						
		e product every 2 hours plus or						
		and as needed, change as						
		otective skin care with each						
	incontinence episo	e plan indicated the pressure						
		n 4/7/17, there was no						
		irrent pressure ulcers on the						
		If direction to keep position off						
	these ulcers.							
		s on 7/26/17, at 8:30 a.m. to						
		s positioned slightly on right						
		b the back, facing the doorway. B's incontinent brief and verified						
		vere wet. Observations at that						
		ncontinent brief was heavily						
		itions at that time revealed						
		3 with a clean incontinent brief						
	and clean bedding.							

Facility ID: 00149

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
			A. BUILDING	i		
		245223	B. WING		07	/28/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET		
	NG HEALTH CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
	repositioned every had a wound on the During interview or verified R23's care pressure ulcer hea R23's care plan wa pressure ulcers re- area. During interview or director of nursing R23 to be repositio according to the ca expected R23 was right side where the Care Planning polic Policy-individual, re be initiated upon ac interdisciplinary tea stay to promote op residence. In doing considerations are #7-Care plans show conferences to refli- individual resident a information update resident's care plar changes. Interdisco confer with each ot interventions that in avoid miscommuni 483.21(b)(3)(ii) SEI PERSONS/PER Care (b)(3) Comprehens The services provide	two hours. NA-D stated R23 eright buttock. 17/27/17, at 10:51 a.m., RN-A plan stated right ischium led 4/7/17. RN-A verified as not updated when the developed on the right hip 17/26/17, at 12:01 p.m., (DON) stated she expected ned every 2-2 1/2 hours are plan. DON stated she not to be positioned on the ere were open skin wounds. cy dated 11/2016: esident centered care planning dmission and maintain, by the am throughout the resident's timal quality of life while in a so, the following made: uld be updated between care ect current care needs of the as changes occur. Any d or discontinued in the n will include the date of the iplinary team members must her prior to changing hvolve multiple departments to cation. RVICES BY QUALIFIED ARE PLAN	F 280			8/31/17

Facility ID: 00149

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. (X3) DATI	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	NG		PLETED
		245223	B. WING _		07/2	28/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
F 282	Continued From pa	ge 12	F 28	32		
	(ii) Be provided by a	-				
	This REQUIREMEN	NT is not met as evidenced				
	review, the facility fa 1 of 1 resident (R62 assistance with per provide range of mo 1 resident (R2) acc and failed to follow	tion, interview, and record ailed to follow the care plan for 2) assessed to need extensive sonal hygiene. Also failed to otion (ROM) exercises for 1 of ording to their plan of care, the care plan for 1 of 1 th pressure ulcers and		F 282 Following Care Plan Immediate corrective action: Resident # 2 will receive ROM po Plan. Resident #23 will receive with each incontinent episode. N was counseled and re-educated need to provide peri-care with ea incontinent episode. Resident # provided a personal shaver and assist to shave as needed. Action as it applies to others: The Policy and Procedure on following the second state of the secon	peri-care IAR-D on the Ich 53 was staff will	
	identified R62 with	ta Set (MDS) dated 5/2/17, severe cognitive impairment sive assist of 1 with personal		Care Plan for personal needs wa reviewed and remains current. T and Procedure on Incontinent/Pe care was reviewed and remains All residents needing staff assist	is The Policy erineal current.	
		ed 6/25/15, identified R63 with ssistance with shaving or s upon discovery.		shaving, ROM and incontinence were reviewed to assure needs Care Planned. All nursing staff will be in-service	were	
	R62's kardex dated 7/27/17, identified R63's grooming needs assist with shaving or pluck facial hair upon discovery per R63's wishes.			8/31/17 (date) on providing n Care Plan/Care Card, which will shaving, providing ROM and inco care.	eeds per include	
	was sitting on the c during a scheduled noted to have seven During subsequent 9:35 a.m., 7/26/17,	on 7/24/17, at 4:07 p.m., R63 ouch in the common area singing activity and R63 was ral long unshaven chin hairs. observations on 7/25/17, at at 12:53 a.m., and on 7/27/17, ontinued to have long, 's.		Date of completion:8/31/17_ Recurrence will be prevented by Visual audits of residents weekly assure ROM, shaving needs and incontinence care are provided w conducted x90 days and results with the facility QAPI committee for input on the need to increase	y to l vill be shared monthly	

Facility ID: 00149

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CENTERS FOR MEDICARE & MEDICAID SERVICES	O	RINTED: 08/21/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
245223 B. WING		07/28/2017
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
I RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGPREFIX TAGTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
 F 282 Continued From page 13 During interview on 7/26/17, at 1:52 p.m., nursing assistant (NA)-B verified that R63 should have had facial hair shaved. Further stated R63 does not have her own personal shaver to be shaved. When interviewed on 7/26/17, at 1:57 p.m., NA-C verifies that R63 needs extensive assist to help with shaving per the care plan and that R63 should have had her chin hairs shaved. During interview on 7/27/17, at 7:48 a.m., registered nurse (RN)-D verified that R63 should have had her chin hairs shaved and stated, "This is my worst fear living in a nursing home and to have all those facial hairs." Interview on 7/27/17, at 8:51 a.m., director of nursing (DON) verified her expectation is to shave each resident as needed and to follow the care plan as directed. DON further stated they would contact social services to get R63 a personal shaver. R2's quarterly Minimum Data Set (MDS), dated 6/21/17 identified R2 diagnoses of intracranial injury and functional quadriplegia. R2 functional limitation in ROM is impaired on both upper and lower extremities requiring R2 to be total dependent on staff for transfers and requires extensive assistance for bed mobility, dressing and personal hygiene. Record review of the visual/bedside kardex report (a report nursing assistants can review on computer of cares for the residents) identified nursing rehab/restorative staff assist of one to provide passive ROM to left upper and lower extremity 15 repetitions (reps) per joint 3 times per week. 		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/2	28/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	NG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	R2's care plan reco motion. The care pl for staff to perform extremity and left lo three times a week. an intervention stati support R2 in her st and offer reassuran continue to enjoy ar request. Director of nursing y 7/27/17 at 1:01 p.m received one day of days. No evidence of ROM according to facility R23 had diagnosis failure with hypoxia, neurogenic bowel, r bladder and seizure physician progress Facility identified R2 Data Set (MDS), 4/4 term memory proble decision making, to for activities of daily mobility, transfers, o hygiene, always ino bladder, pain unable limitation in range o unstageable press	gnizes limited range of an also identified R2 the need passive ROM to left upper over extremity 15 reps per joint . R2 care plan also identifies ing staff acknowledge and truggle with her limited mobility ace and assistance so R2 can active lifestyle per R2's verified in an interview on . the resident had only f ROM services in the last 30 resident refused to do the care plan. o the facility on 7/14/16, Admission Record. that included acute respiratory , traumatic brain injury, neuromuscular dysfunction of es, according to facility note dated 7/25/17. 23 on the quarterly Minimum 4/17, to have short and long em, severely impaired tally dependent on two staff v living which included bed dressing, toileting and continent of bowel and e to answer, functional of motion on both sides, ure ulcer due to slough or cer not present on prior ing tube, tracheostomy,	F 2	282			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/:	28/2017
NAME OF	PROVIDER OR SUPPLIER	·			TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WI	NG HEALTH CENTER				412 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Document review of Assessment (CAA) for urinary incontine of staff for toileting bladder. Diagnosis impaired mobility. S and as needed. R23 was observed on the right hip, pos- incontinent of a larg on the right hip and after urinary inconti Review of R23's ca included the followi Care plan problem bowels and bladder check incontinence minus 15 minutes a needed, provide pro- incontinence episod Document review of Report (NA assign directed to check in hours plus/minus 1 needed, provide pro- incontinence. During observation 8:58 a.m., Nursing R23's incontinent bie Observations at tha provided R23 with a clean bedding. NA	of R23's Care Area dated 7/3/17, had triggered ence due to totally dependent and always incontinent of of neurogenic bladder, has Staff assist every 2-2 ½ hours to have two pressure ulcers sitioned on the right hip, was ge amount of urine while laying d did not receive perineal care inence. are plan print dated 7/26/17, ing directions for staff: of always incontinent of r. Interventions included: e product every 2 hours plus or and as needed, change as otective skin care with each	F 2	282			

Facility ID: 00149

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		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa provided perineal ca incontinent brief on During interview on stated expected per incontinence. During interview on director of nursing (perineal care provid Care Planning polic Policy-individual, re be initiated upon ac interdisciplinary tea stay to promote opt residence. Policy review dated reads; resident cen maintained by the in out the resident sta life, in doing so the made: each reside resident has a right life-patterns as able care planning and e highest practical ph through the nursing Care plans are acce and their responsib routinely of changes	age 16 are before putting new resident. 7/26/17, at 10:30 a.m., LPN-B rineal care with each 7/26/17, at 12:01 p.m., (DON) stated she expected ded after each incontinence. cy dated 11/2016 included, esident centered care planning dmission and maintain, by the um throughout the resident's timal quality of life while in 11/16 titled care planning itered care planning is nterdisciplinary team through by to promote optimal quality of following considerations are ent is an individual, each t to be happy, continue their e, resident are included in encouraged to maintain their hysical and mental abilities g home stay. essible to all direct care staff illity to review the care plan s.	F 2	282			
F 312 SS=D	DEPENDÈNT RES (a)(2) A resident wh	no is unable to carry out	F 3	312			8/31/17
	activities of daily live	ing receives the necessary					

Facility ID: 00149

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. (X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	G		PLETED
		245223	B. WING _		07/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	E	
	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 312	Continued From pa	age 17	F 31	2		
	personal and oral h This REQUIREMEN by: Based on observat review the facility fa shaving as directed residents (R62) and services/cares for residents who were living (ADL). Findings include: R62's Quarterly Min 5/2/17, identified R impairment and red with personal hygie R62's care plan dat an intervention of a plucking facial hairs R62's kardex (nurs resident cares) data grooming needs as	NT is not met as evidenced tion, interview, and record ailed to provide assistance with d by the care plan for 1 of 4 d failed to provide incontinence 1 of 4 residents (R23) for both e reviewed for activities of daily himum Data Set (MDS) dated 62 with severe cognitive quired extensive assist of 1 ene. ted 6/25/15, identified R63 with assistance with shaving or		F 312 Personal Care Immediate corrective action: Resident #23 will receive peri- each incontinent episode. NA counseled and re-educated of to provide peri-care with each episode. Resident #63 was p personal shaver and staff will shave as needed. Action as it applies to others: The Policy and Procedure on Care Plan for personal needs reviewed and remains current and Procedure on Incontinent care was reviewed and remai All residents needing staff ass shaving and incontinence card reviewed to assure needs we Planned. All nursing staff will be in-serv 8/31/17(date) on p needs per Care Plan/Care Ca will include shaving and incon	R-D was a the need incontinent rovided a assist to following the was . The Policy /Perineal as current. istance with a were re Care iced on roviding rd, which	
	was sitting on the c during a scheduled noted to have seve During subsequent 9:35 a.m., 7/26/17, at 7:39 a.m., R63 c unshaven, chin hai	on 7/24/17, at 4:07 p.m., R63 souch in the common area singing activity and R63 was ral long unshaven chin hairs. observations on 7/25/17, at at 12:53 a.m., and on 7/27/17, ontinued to have long, rs.		care. Date of completion:8/31/1 Recurrence will be prevented Visual audits of residents we assure shaving needs and in care are provided will be cond days and results shared with t QAPI committee monthly for i need to increase, decrease of the audits, will also be discuss Quality Conference.	by: ekly to continence ucted x90 he facility nput on the discontinue	

Facility ID: 00149

		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245223	B. WING			07/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa been shaved. Furth her own personal sl When interviewed of verifies that R63 ne shaving per the car have had her chin h During interview on registered nurse (R have had her chin h is my worst fear livin have all those facia Interview on 7/27/17 nursing (DON) verif shave each residen care plan as directe would contact socia personal shaver. R23 was admitted t according to facility R23 had diagnosis failure with hypoxia neurogenic bowel, r bladder and seizure physician progress Facility identified R2 Data Set (MDS), 4/4 term memory proble decision making, to for activities of daily mobility, transfers, o	nge 18 her stated R63 does not have haver to be shaved. on 7/26/17, at 1:57 p.m., NA-C eeds 1 assist to help with re plan and that R63 should hairs shaved. 7/27/17, at 7:48 a.m., 2N)-D verified that R63 should hairs shaved and stated, "This ng in a nursing home and to	- -	312			
	bladder, pain unable limitation in range o	e to answer, functional of motion on both sides, ure ulcer due to slough or					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245223	B. WING	i		07/:	28/2017
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	NG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	eschar, pressure ul assessment, feedin suctioning, oxygen. The facility identifie dated 6/19/17, sam identified with no pa Document review of Assessment dated included impaired n staff for transfers, of bladder, clothes an Analysis indicated i bladder, has diagno staff assist R23 with Review of R23's ca included the followi	lcer not present on prior ng tube, tracheostomy, ed R23 on the annual MDS ne as 4/4/17 MDS, and was	F3	312			
	bowels and bladder check incontinence minus 15 minutes a needed, provide pro- incontinence episod Document review of Report (NA assign directed to turn and with two staff assist dependent on staff, 2-2.5 hours, inconti check incontinence plus/minus 15 minu provide protective s incontinence.	r. Interventions included: e product every 2 hours plus or and as needed, change as otective skin care with each					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 08/21/2017 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245223	B. WING _		07/	28/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
RED WIN	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 312	positioned slightly of back, facing the dou incontinent brief and were wet. Observati incontinent brief wa Observations at tha R23 with a clean ind bedding. However, completed before th put on the resident. provided perineal ca 10:30 a.m., licensed perineal care should incontinence episod RN-A verified R23's bowel and bladder, with each incontine protective skin care after each incontine expected to provide incontinence episod During interview on director of nursing (perineal care provide male indicated-if sto wipes, wet wash clo spray or use perine urethra and work ou	time revealed R23 was on right side with a pillow to the orway. NA-D checked R23's d verified the brief and bed tions at that time revealed the s heavily saturated. It time revealed NA-D provided continent brief and clean no perineal care was he new incontinent brief was NA-D verified had not are after incontinence. d practical nurse-B stated d be done after every de. care plan for incontinence of directed protective skin care int episode. RN-A stated was the use of barrier cream ence. RN-A said staff were e perineal cares with each de. 7/26/17, at 12:01 p.m., DON) stated she expected ded after each incontinence. y dated 10/2015 included, for pol present use perineal oth and apply skin cleansing al wipes, wash starting with utward, retract foreskin, wash er thighs, gently pat dry,	F 31	12		
F 314 SS=D	483.25(b)(1) TREA	TMENT/SVCS TO	F 31	14		8/31/17

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 08/21/2017 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (X3) D	ATE SURVEY DMPLETED
		245223	B. WING	i	0	7/28/2017
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
RED WIN	G HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From pa	ge 21	F:	314		
	(b) Skin Integrity -					
	(1) Pressure ulcers comprehensive ass facility must ensure	essment of a resident, the				
	professional standa pressure ulcers and ulcers unless the in	es care, consistent with Irds of practice, to prevent I does not develop pressure dividual's clinical condition hey were unavoidable; and				
	necessary treatmer professional standa healing, prevent info from developing.	oressure ulcers receives at and services, consistent with ords of practice, to promote ection and prevent new ulcers NT is not met as evidenced				
	Based on observat review, the facility fa interventions to pro	ion, interview and document ailed to implement mote healing for 2 of 3)) with pressure ulcers.			F314 Pressure Ulcer Immediate corrective action: Resident 23 is able to move self in bed somewhat "scoots" himself often out of position placed into. Therapy reviewed repositioning plan for addition input.	
	R23 was admitted t according to facility	o the facility on 7/14/16, Admission Record.			Resident 70 will be repositioned and hee floated per care plan.	
	diagnosis to include hypoxia, traumatic l neuromuscular dyst seizures.	ian notes dated 7/25/17 list of acute respiratory failure with orain injury, neurogenic bowel, function of bladder and			Action as it applies to other: All residents with PU will be reviewed to assure their repositioning needs are Car Planned. All nursing staff will be in-serviced on repositioning needs of residents on 8/31/17. Repositioning times will continue to be documented. 8/31/17	
	Data Set (MDS), 4/4	23 on the quarterly Minimum 4/17, to have short and long em, severely impaired			Recurrence will be prevented by: Visual audit of 3 residents weekly needing staff	

Facility ID: 00149

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING		COMPLETED		
		245223	B. WING		07/	28/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE		
F 314	decision making, to for activities of daily mobility, transfers, thy pain unable to answ range of motion on pressure ulcer due ulcer not present of tube, tracheostomy The facility identifie dated 6/19/17, sam was identified with Document review of assessment to eval include bony promi which could cause following: 3/28/17-no redness pressure reducing n ½ hours. 4/28/17-no redness remain on 2-2 ½ ho 6/2/17- no redness reducing mattress, Document review of Assessment for Pre dated 4/28/17, and high risk for develo moist; chair fast-ab non-existent; mobil occasional slight ch position but unable significant changes shear are a problem	otally dependent on two staff y living which included bed dressing, toileting and continent of bowel and bladder, wer, functional limitation in both sides, unstageable to slough or eschar, pressure in prior assessment, feeding y, suctioning, oxygen. d R23 on the annual MDS te as MDS dated 4/4/17, and	F 31	4 assistance with reposition to assi compliance and documentation of will be conducted x 90 days and shared monthly with the facility C committee for input on the need r increase, decrease or discontinu audits. the correction will be monitored to DON/Designee	of times results API to e the			

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		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245223	B. WING	i		07/	28/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	NG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	••••••••••••••••••••••••••••••	-	F:	314			
	frequent repositioni	own in bed or chair, requiring ing with maximum assistance, ures or agitation leads to ction.					
	Evaluation of Skin I dated 4/28/17, reve developing pressur included head of be required assist with medical devices su diagnosis if brain in unstageable pressu centemeters (cm) b Analysis indicated F pressure ulcer relat existing pressure in mobility and inconti	of facility Comprehensive Inspection and Risk Factors ealed R23 was at high risk for e sore; other risk factors ed elevated majority of the day, a activities of daily living, had ch as oxygen tubing; njury; had right ischium ure ulcer measuring 2 by 1 cm by 0.1 cm depth. R23 was at risk for developing ted to immobility, already njury, assistance with all nence, pressure relieving remains on a turn and					
	reposition every two Document review o Evaluation of Skin I dated 6/2//17, revea assessment, excep unstageable pressu 1.5 cm by 0.05 cm wound had worsen and deeper, continu daily, turn and repo wheelchair a couple staff assist with turr wheelchair and with Document review o Assessment (CAA) triggered for pressu	o hours. of facility Comprehensive Inspection and Risk Factors aled all areas same as 4/28/17 of the right gluteal fold ure ulcer measured 4 cm by depth. Analysis indicated R23 ed since hospital stay, is larger ue to do dressing changes isition every 2-2 ½ hours, up in e times a day and requires two hing and repositioning in h all mobility.					

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		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245223	B. WING	i		07/	28/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	of bowel and bladde on right ischium un mattress and whee Review of R23's ca revealed the followi R23 currently had a ischium (healed 4/7 pressure ulcers. Int relieving mattress of notify physician/nur worsens, follow elim reposition every 2-2 observe skin daily a plan problem of alw bladder. Interventio incontinence produc 15 minutes and as provide protective s incontinence episod Document review o Report (a Nursing A sheet) revealed NA every 2-2.5 hours w unable to help at all in wheelchair every bowel and bladder, every 2 hours plus/n needed, provide pro- incontinence. The following obser dated 7/26/17 at 7:0 asleep in low bed, a R23 was positioned a pillow at the back the doorway. At 7:1	er, and had a pressure ulcer istageable. Required special lchair cushion. are plan print dated 7/26/17, ing directions for staff: an unstageable area on right 7/17) and is at risk for more rerventions included: pressure on bed, treatments as ordered, se practitioner if wound nination care plan, turn and 2.5 hours assist of 2 staff, and weekly with bathing. Care vays incontinent of bowels and ns included: check ct every 2 hours plus or minus needed, change as needed, skin care with each	F	314			

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY			
ND PLAN (OF CORRECTION		A. BUILDING			MPLETED			
		245223	B. WING		07	//28/2017			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
	RED WING HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE			
F 314	Continued From pa		F 31	4					
	the tube feeding and started a nebulizer treatment. R23 remained in the same position slightly on the right side facing the door. At 7:27 a.m., same position as at 7:02 a.m. During observations on 7/26/17, at 8:21 a.m., LPN-B entered R23's room, discontinued the nebulizer treatment. During interview at that time, LPN-B verified had not repositioned R23 at that								
	time. R23 was obse right side with a pill positioned facing th	ow at the back. R23 was ne doorway. At 8:30 a.m., htly on right side facing the							
	door. At 8:45 a.m., side facing door wit a.m., LPN-B entere	same position, slightly on right th a pillow at the back. At 8:52 of R23's room, asked if R23 PN-B explained would get R23							
	up in a while. R23 r the right side, facin nursing assistant (N	remained positioned slightly on g the door. At 8:58 a.m., NA)-D entered R23's room. time revealed R23 was							
	positioned slightly o back, facing the do incontinent brief an	on right side with a pillow to the orway. NA-D checked R23's d verified the brief and bed							
	incontinent brief wa Observations at tha	ations at that time revealed the as heavily saturated. at time revealed NA-D a clean incontinent brief and							
	clean bedding. No the visible areas of stated R23 was to l	red areas were observed on right hip and back. NA-D be repositioned every two							
	buttock. Observation right wound dressing	R23 had a wound on the right on at that time revealed one ng with hand written date of During interview at that time,							
	NA-D verified R23 NA-D verified had r	had a large urine incontinence. not provided perineal care after 11 a.m., NA-D verified did not							

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		. 0938-039 E SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	3		COMPLETED			
		245223	B. WING		07/28/2017				
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•				
	RED WING HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE			
F 314	checked for inconti nursing assistant (I left side, facing the back and between verified R23 had a At 9:24 a.m., NA-A R23's morning care cares are done bet At 9:39 a.m., NA-G morning cares for F morning cares wer at 6:30 a.m., which perineal care and r R23 was reposition 8:30 a.m., by LPN- went to R23's room nebulizer treatment cares for R23 at the stated the facility do repositioning of R2 repositioning of R2 stated R23 would h between 6:00 a.m. LPN-B verified the of when R23 was r LPN-B stated expe incontinence. At 11 registered nurse (F transfer R23 from v mechanical lift, rem	nence. At 9:12 a.m., NA-D and NA)-A, positioned R23 on the window, with pillows at the the legs. NA-D and NA-A wound on the right buttocks. stated NA-G had completed es. They stated all residents ween 7:00 a.m., and 8:00 a.m. stated had not completed R23. NA-G stated R23's e completed by the night shift included washing, dressing, epositioning. NA-G stated ned between 8:00 a.m., and B. At 9:45 a.m., LPN-B verified n at 8:21 a.m., removed t. LPN-B verified did not do any at time. LPN-B and NA-A, oes not document 23. LPN-B stated expected 3 every two hours. LPN-B nave been repositioned to 6:30 a.m., by the night shift. facility had no documentation epositioned. At 10:30 a.m., cted perineal care with each :04 a.m., NA-A, NA-G and RN)-A, were observed to wheel chair to bed with a noved slacks, and positioned he window while RN-A	F 314	4					

Facility ID: 00149

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
and plan (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO		
		245223	B. WING		07/28/2017		
NAME OF	PROVIDER OR SUPPLIER		S	DE			
	IG HEALTH CENTER		1412 WEST FOURTH STREET RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 314	drainage on the dre cleansed the woun medi-honey to the appeared approxim eschar in the center color. Review of the with dispense date to wound every eig wounds with foam positioned on the le pillows to the back stated the right hip stated she does wo staff nurses comple week. RN-A verified started on 7/25/17. issues with faxing of with pharmacy deliv verified medi-honey delivered for severa had been notified of when ordered. RN- for debridement of canceled due to is nurse to go with R2 stated R23 was res 7/31/17, at 1:00 p.r as unstageable with is stage 4, and dres drainage. RN-A sta also have been soa incontinence. RN-/ have wound dressi expected R23 to be	age 27 essing and foul odor. RN-A d with sterile water, applied white eschar. The wound nately 3 centimeters with white er, edges were dark pink in ne medi-honey pharmacy label of 7/25/16, revealed to apply ht hours. RN-A covered both dressings. R23 was eff side facing the window with and between the legs. RN-A red area was new. RN-A ound care on Mondays and ete wound care the rest of the d medi-honey treatment RN-A stated the facility had order to pharmacy and issues vering the medi-honey. RN-A y had been ordered but not al days. RN-A stated physician of not starting the medi-honey A stated R23 was scheduled the wound recently, was sue with transportation and no 23 to the appointment. RN-A scheduled for debridement on n. RN-A described the wound h eschar, outside eschar area ssing soaked with tan ated the foam dressing could aked with urine due to the large A stated it was usual for R23 to ng soaked. RN-A stated she e repositioned every two hours, ide and back to back again.	F 314				

Facility ID: 00149

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	08/21/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245223	B. WING	i		07/2	28/2017
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WING HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
right hip. RN-A state had appeared befor stated she expected incontinence. RN-A pressure ulcer had On 7/27/17 at 12:01 (DON) stated she e repositioned every 2 care plan. DON sta not to be positioned DON stated she exp each incontinence. The following obser dated 7/27/17 at 8:1 side facing the wind During interview at was just repositioned dressing change lat nursing assistant (N be repositioned ever incontinence every cared for R23, who (new fracture) and y the right side. NA-H after each incontine nursing assistant (N repositioned every t incontinence every a kardex with instru closet door. NA-I st had a wound on the positioned nte rig provide pericare aft 10:35 a.m., observa positioned R23 to th	r sometime, positioned on the ed the red area on right hip re and then goes away. RN-A d perineal care after each A verified the unstageable declined.	F	314			

Facility ID: 00149

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STATEMEN	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		TE SURVEY		
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CO	COMPLETED		
		245223	B. WING		07/28/2017			
NAME OF	PROVIDER OR SUPPLIER			E				
	IG HEALTH CENTER		1412 WEST FOURTH STREET RED WING, MN 55066					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 314	ischium. RN-A rem dressing to right hip measured 3 cm by drainage. RN-A ap red area. RN-A ren dressing, saturated measured 5.5 cm b depth, with 75 perc cleansed the wound medi-honey and co absorbent dressing R23 onto back with At 10:51 a.m., inter R23 had previously side, unstageable v 7/26/17. RN-A state were doing the righ right side, off of left Reviewed Weekly V with RN-A and dur the facility Weekly V dated 6/19/17 to 7/2 unstageable presso During interview at right ischium wound was measured on 3 and unstageable. F tissue tolerance ev a wound develops a hospital. RN-A verifi right ischium press was a different ulce plan was not revise found on 3/28/17. F hospitalized from 4	oved the smaller foam o to reveal red area which 2 cm, blanchable and no plied a foam dressing to the noved larger right hip with tan drainage, wound by 3.9 cm by 1.1 cm and 2 cm ent eschar per RN-A. RN-A d with sterile water, applied vered the wound with a white b. RN-A and NA-H positioned pillows between the legs. view RN-A verified was aware been positioned on his right vound on the morning of ed the night staff thought they t thing by placing R23 on the	F 314					

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STATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	· · /	IPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED		
		245223	B. WING		07/28/2017			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
RED WII	NG HEALTH CENTER		1412 WEST FOURTH STREET RED WING, MN 55066					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE		
F 314	determine if the fra home. RN-A verifie dated 5/4/17, identi right ischial ulcerati hospitalization, app verified R23's care and bladder, directe each incontinent ep skin care was the u incontinence. RN-/ direction to provide incontinence becau order of care, staff each incontinence. no way to identify w and checked for inc may be dry all nigh incontinence. RN-/ 7/14/17, to repositio verified the care pla 2-21/2 hours. RN-/ dated 7/17/17, for r verified the treatme when the ointment after the order. RN- to obtain medi-hom progress note date physician identified canceled and phys RN-A stated the de to not having the rig had been reschedu due to no staff avai stated the right hip 7/25/17, at 1:00 p.r scheduled for 7/31/ physician progress was for a fall and h	cture occurred at the nursing ed physician progress note ified one- stage 2 decubitus	F 3 ⁻					

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			(X2) MULTIPLE CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED	
		245223	B. WING		07	//28/2017	
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COL	θE		
RED WIN	IG HEALTH CENTER		1412 WEST FOURTH STREET RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 314	Continued From pa	age 31	F 31	4			
	Form dated 4/7/17 4/13/17, identified r RN-A verified R23 4/11/17, with a hea the physician on 4/ hospitalized 4/23/1 the left hip fracture RN-A verified signit dated 4/23/17, which approximately 5 cm area was an open a on right buttock up R23 was sent to the evaluation of left hi developed right isc on 4/7/17, developed measuring 5 cm by	ficant change progress note ch identified a large red area n by 3 cm and inside the red area measured 3 cm by 1 cm per thigh crease. RN-A stated e hospital on 4/23/17, for p fracture. RN-A verified R23 hial ulcer on 3/28/17, healed ed again on 4/23/17, / 3 cm and 3 cm by 1 cm open, 3/17, and returned 4/28/17					
	Documentation For 3/31/17-pressure (f centimeter (cm) by drainage, no odor. analysis-we current plan. treatm cream. 4/7/17-pressure rig unstageable,no odo is healed. treatment-re	of facility Weekly Wound rm revealed the following: ulcer) right ischium 1 1 cm, unstageable, no ound unchanged, continue nent-repositioning and barrier ght ischium, 0 cm by 0 cm, or, improved. analysis- wound epositioning and barrier cream. ght ischium, 2 cm by 1 cm by					

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		& MEDICAID SERVICES	(X2) MUU	TIPI	LE CONSTRUCTION	MB NO.	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				PLETED
		245223	B. WING			07/2	8/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 314	Continued From pa	age 32	F 3	314			
	0.1 cm depth, unsta improved. analysis- or fracture, pressure r cover with foam da 5/19/17-pressure ri	ght ischium, 2 cm by 0.8 cm by ageable, no drainage, no odor, n bedrest related to hip reducing mattress in place, ily. ght ischium, 3 cm by 0.5 cm, nstageable, no odor, no					
	hours. cover with fo 6/12/17-pressure ri by 0.1 cm depth, un odor, improved, analysis-re reposition, wound r wound wash, santy as an enzymatic de	ght ischlum, 2.8 cm by 0.5 cm nstageable, no drainage, no mains on 2-2.5 hour remains same. Cleanse with (a collagenase ointment used ebriding ointment) to eschar,					
	6/19/17-pressure ri 0.5 cm depth, pres drainage, no odor, analysis-remains s every 2-2.5 hours,	essing, change daily. ght ischium, 3 cm by 4 cm by sure, unstageable, no progress is no change, ame size, turn and reposition cleanse with wound wash, ar, cover with foam dressing,					
	by 0.5 cm depth, st serosa progress-no chang analys reposition every 2-2	anguinous drainage, no odor, e, is-remains same size, 2.5 hours. cleanse with I wash, santyl to eschar, cover					
	7/4/17-pressure rig no depth identified,	ht ischium, 4.7 cm by 3.1 cm, unstageable, and moderate drainage,					

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TATEMEN	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	D. 0938-039 TE SURVEY MPLETED		
				NG				
		245223	B. WING			//28/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
RED WII	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 314	odor-y cleans eschar, cover with change analys times a day, contine dressin reposition every 2-2 7/17/17-pressure ri 1.3 cm depth, unsta drainag cleanse with wound eschar change daily, progr analys drainage, eschar is is able reposition every 2-2 to phys debridement for lef unstag 7/24/17-pressure ri by 2 cm depth stag drainag ischial wound care- wound eschar/slough, cov dressin analysis-continue c medi-f 7/31/17 for debride	es, e with wound wash, santyl to foam dressing, e daily. is- augmentin (antibiotic) two ue with current ng change, remains on 2.5 hours. ght ischium, 5 cm by 3 cm by ageable, scant ge, serosanguinous, no odor, d wash, santyl to r, cover with foam dressing, ess-declined, is- no longer has green loosening and depth to be measured, remains on 2.5 hours, refer sician for surgical/mechanical t ischium yeable pressure ulcer. ght ischium, 5 cm by 3.5 cm e 4, heavy ge, tan color, no odor, right cleanse with wash, apply medi-honey to er with foam ng, change every 8 hours, urrent treatment of noney, has appointment on ment of wound.	F 31					

		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245223	B. WING	i		07/	28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 34	F	314	ł		
	today, continues to right gluteal fold me 0.5 cm in depth, ha	from hospital about 1 p.m. have trachea in, wound on easures 4 cm by 1.5 cm and d worsened since left the ed on 6/2/17, R23 was lying on 40 degrees angle.					
	appeared to have n wound, this has hap week, also laying or side. The note state wound, complete be R23 so brief would	ares at 8:30 a.m., R23 to foam dressing over right hip ppened multiple times in last n right side and not on the left ed brief lines exactly on top of ed change and put pad under not irritate the wound. The w mark above the wound that by 3.5 cm.					
	On 7/22/17 a red ar cm by 3 cm and bla	rea on right hip measured 2.5 anchable.					
	lack of medi-honey indicated that on 7/19/17, 7/20/17, ar	f progress notes related to that was ordered on 7/17/17 nd 7/25/17, staff called the obtain medi-honey.					
	7/25/17, revealed d	of the right hip x-ray dated legenerative joint disease of dence to indicate osteomyelitis					
	the following orders On 7/14/17-repositi On 7/17/17-right isc wound wash, apply						

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	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MI II T	IPLE CONSTRUCTI	ION		<u>O. 0938-039</u> ATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	` '				OMPLETED	
		245223	B. WING _			07/28/2017		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRES	CODE			
RED WIN	IG HEALTH CENTER			1412 WEST FOU RED WING, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CO CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 314	Continued From pa	age 35	F 31	14				
	On 7/25/17-X-ray r osteomyelitis).	ight hip (evaluate for possible						
pi O le O ui oi O fe fri	Document review of physician/nurse practitioner progress notes revealed the following: On 3/14/17-skin warm and dry, no suspicious lesions or wounds.							
	unstageable press on ischium.	ned a fall overnight and ure ulcer was found 3/28/17,						
	hospitalization. Dia two decubitus right to hospitalization, a	ignosis also indicated a stage t ischial ulceration found prior appears to be worse.						
	wound was found to Skin warm and dry	ssessment visit, the sacral to have no dressing in place. , has right ischial tuberosity						
	cm covered with bl 0.5 erythema arou	ble, approximately 4 cm by 1.5 ack eschar and approximately nd the perimeter, no drainage,						
	emergency room c temperature, cons	note indicated R23 was in the over the week-end for elevated tipation and chest x-ray						
	On 6/9/17-impress On 7/14/17-ordere	d to reposition every 2 hours to						
	been referred to ge appointment previo	pressure to the area. R23 has eneral surgery, had an busly but was discontinued due						
	appointment. Will needed debrideme							
	visit for follow up o	ed R23 was seen for acute f right ischial pressure ulcer. on 7/14/17. R23 had a						

Facility ID: 00149

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING	·		07/:	28/2017
NAME OF	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	IG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	for debridement of told by healthcare of appointment was car available to accomptold no follow-up ap Nursing reports ulcar increased drainage medication given was pressure ulceration appears to be necros R23 had significant palpated the edges malodorous. There that is blanchable. Iast provider visit, wo not yet been started on right hip, which p showed a 2.5 cm refoam has been appassessment and plaulceration. Will do possible osteomyel scan due to contract previous wound cul was on augmentin Physician spoke to it is currently not av coming in today at 2 appointment for del canceled without physician spoke to it should not be postport. Document review of dated 4/23/17, reverse abdominal pain and buttocks stage 1 definition.	pressure ulcer. Physician was coordinator today that this anceled due to no nursing staff panying R23. Physician was pointment had been made. eration is malodorous, possible pain, pain ith good effect. Right ischial was examined, wound bed btic and larger than last exam. grimacing when physician of wound. Wound was is a 2 cm red area on right hip Medi-honey was ordered after thich physician was told, had d. There is also a new area per nursing notes on 7/22/17, ed area which is blanchable. A lied to this area. Physician an-unstageable right ischial a right hip X-ray to assess for itis, will consider doing CT ctures, ordered blood work, ture was polymicrobial and (antibiotic) for 10 days. nursing about medi-honey as ailable. Nursing said it was 2 p.m. Physician asked for oridement as this was hysician knowing. Physician is medically necessary and	F	314			

		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245223	B. WING			07/2	28/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 37	F	314			
	revealed the followi On 4/11/17-unstage ischium on 3/28/17 On 4/23/17-has larg by 3 cm inside red a cm on right buttock cleansed and foam to off- load pressure On 7/23/17-nursing orders-right ischial wash, apply mediho with foam dressing. During interview on medical doctor (MD unstageable pressure facility. MD-A state dressing on the wor positioned on the u stated not aware the was canceled beca go with R23 to the a changed the wound medi-honey and wa had not obtained the During interview on director of nursing (R23 to be reposition according to the ca expected R23 was right side open wou perineal care after of During interview on	eable pressure ulcer found on ge red area approximate 5 cm area is open area 3 cm by 1 upper thigh crease, area dressing applied, positioned e in the area. progress note identified wound, clean with wound oney to eschar/slough, cover , change every 8 hours. 7/25/17 at 9:33 a.m., R23's 0)-A stated R23 had a new ure ulcer which started in the d on three occasions found no und and have found R23 instageable wound. MD-A e debridement appointment use no staff were available to appointment. MD-A stated had d treatment recently to as not aware that the facility e ointment timely. 7/26/17, at 12:01 p.m., (DON) stated she expected ned every 2-2 1/2 hours re plan. DON stated she not to be positioned on the und. DON stated she expected					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/2	28/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	R70's Minimum Da indicated R70 had u required assistance mobility and had a d MDS further indicat pressure ulcer and pressure ulcer. The a pressure reducing received pressure u ointments/medication Kardex Report print was to be assisted every 2 hours-2.5 h members and off for every 2 hours-2.5 h members and off for every 2 hours. The was to have a heel heels off the bed al for incontinence even R70's Treatment Ac dated 1/16/16, indic was to ensure that for turning, reposition A Turn and Reposit Plan Task Sheet for marks for every shi 6/27/17, and 7/25/1 was conducted on remain on a 2-2.5 h schedule. Skin Assessment p through 7/26/17, re 4/17/17, left lateral length, 1 centimete unstageable depth. measurement only:	ta Set (MDS) dated 5/11/17, no cognitive impairment, e of two persons for bed diagnosis of quadriplegia. The ed R70 had one stage III was at risk of developing a e MDS also indicated R70 had g device for his chair and bed, alcer care and applications of ons. R70's Visual/Bedside ted on 7/27/17, indicated he with turning and repositioning ours with an assist of two staff ad when in his wheel chair report further indicated R70 elevating cushion to keep the time, and to be checked ery 2 hours. dministration Record (TAR) cated that every shift the nurse staff were following care plan oning and documentation. ion and Offloading Per Care r R70 did not have check ft on 14 days between 7. A Tissue Tolerance (TT) 7/14/17, with plan for R70 to nours turn and reposition rogress notes from 4/7/17, vealed the following: heel measurement only: r (cm) x width 1 cm x 5/11/17, left lateral heel 1.5 x 1.2 x stage III. 6/12/17, surements: anterior: 0.4 x 0.2	F	314			

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		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/2	28/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	NG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	unstageable. 7/24/1 measurements: and and posterior 0.25 or right heel scar tissue 4 x stage II. During continuous of 7:05 a.m. to 10:24 a R70 was observed without being repose checked for incontin queried two staff m Nurse (RN)-A and F regarding reposition subsequently repose raised off of the beat On 7/26/17, at 10:4 RN-A confirmed R7 repositioned since of had been resting or confirmed there wa area on R70's right coccyx area had a f area. RN-A stated F turned and reposition heels should have F On 7/26/17, at 11:0 R70 he stated he is for over 3 hours even happens I get stiff a opening up. On 7/26/17, at 12:3 Nursing Assistant (f be turned and reposition	17, left lateral foot terior 0.5 x 0.5 x unstageable x 0.25 unstageable. 7/26/17, ue 1.5 x 1.0 and coccyx: 4.5 x observation on 7/26/17, from a.m. (3 hours and 19 minutes) laying in his bed on his back sitioned (off loaded) or nence. At 10:24 a.m. writer embers in hallway, Registered RN-B, and voiced concern ning of resident. Resident was sitioned and his right heel was	F3	314			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) D/	IO. 0938-0391 DATE SURVEY COMPLETED
)7/28/2017
245223 B. WING 0	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
RED WING HEALTH CENTER 1412 WEST FOURTH STREET RED WING, MN 55066	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATEDEFICIENCY)DEFICIENCY)DEFICIENCY	(X5) COMPLETION DATE
F 314 Continued From page 40 F 314 DON stated her expectations for turning and repositioning residents would be based on assessments and reflected in the resident's care plan. F 314 On 7/27/17, at 8:24 a.m. during an interview, RN-A stated she had reviewed R70's wounds and he had a new pressure ulcer to his coccyx area that was not present one week ago and his right heel has an area of scar discoloration which she will monitor to see if it is a pressure ulcer or old scar tissue. RN-A further indicated that turning and repositioning of R70 needs to be done every two hours or wounds could develop. On 7/27/17, at 1:53 p.m. during an interview, RN-A stated documentation by NAs had multiple missing check marks under R-70's turning and repositioning log between 6/27/17, and 7/25/17, so it was not known if R70 was repositioned or not on those shifts. The facility Prevention of Pressure Ulcers Policy and Procedures dated 2/2014, General Preventive Measures for a Person in Bed directed staff to change resident's position at least every two hours or more frequently if needed. Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 1: Nonblanchable Erythema: Intact skin with non-blanchable retheres of a localized area usually over a bony prominence. Darkly pigmented skin many ont have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.	

		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY IPLETED
		245223	B. WING	i		07/:	28/2017
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	IG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Stage 2: Partial Thi thickness loss of de open ulcer with a re slough. May also pr open/ruptured seru shiny or dry shallow bruising. Stage 3 Pressure L skin, in which adipo and granulation tiss edges) are often pr devitalized tissue, tr adherent on the tiss dead tissue) may b tunneling may occu ligament, cartilage a lf slough or eschar loss this is an Unsta Stage 4 Pressure L tissue loss with exp fascia, muscle, tend bone in the ulcer. S visible. Epibole (roll and/or tunneling off obscures the exten Unstageable Press full-thickness skin a skin and tissue loss damage within the because it is obscu slough or eschar is 4 pressure ulcer wil (i.e. dry, adherent, i	ickness Skin Loss: Partial ermis presenting as a shallow ed pink wound bed, without resent as an intact or m-filled blister. Presents as a vulcer without slough or Ulcer: Full-thickness loss of ose (fat) is visible in the ulcer sue and epibole (rolled wound resent. Slough (yellow hat can be stringy or thick and sue bed) and/or eschar (dark, e visible. Undermining and ur. Fascia, muscle, tendon, and/or bone are not exposed. obscures the extent of tissue ageable Pressure Ulcer. Ulcer: Full-thickness skin and bosed or directly palpable don, ligament, cartilage or Slough and/or eschar may be led edges), undermining ten occur. If slough or eschar t of tissue loss this is an ure Ulcer. ure Ulcer: Obscured and tissue loss. Full-thickness is in which the extent of tissue ulcer cannot be confirmed tred by slough or eschar. If removed, a Stage 3 or Stage II be revealed. Stable eschar intact without erythema or heel or ischemic limb should	F	314			

		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DAT	E SURVEY IPLETED
		245223	B. WING	i		07/	28/2017
NAME OF I	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	NG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 42	F:	314			
	non-blanchable dee discoloration. Intact localized area of per red, maroon, purple separation revealing filled blister. If necret tissue, granulation funderlying structure full thickness press 3 or Stage 4). Policies provided by Prevention of Press General Guidelines Indicated pressure when a resident ren an extended period pressure or a decret to that area and sul The most common where the bone is r pressure ulcers are continual pressure, substances on resid feces, urine, wound decline in nutrition a illness and/or declir or mental condition Interventions and P change position at f frequently if needed minimum of a 2 hou Risk Factor-Bowel a	sure Ulcers dated 2/2014: ulcers are usually formed mains in the same position for l of time causing increased ease of circulation (blood flow) bsequent destruction of tissue. site of a pressure ulcer is near the surface of the body. e often made worse by heat, moisture, irritating dent's skin (i.e., perspiration, d discharge, soap residue, etc) and hydration status, acute he in resident's physical and / Preventive Measures-indicated least every 2 hours or more d. Place resident on a ur check and change program. and Bladder (continence at least clean skin when soiled.					

		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
1		245223	B. WING	i		07/:	28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	For male indicated- wipes, wet wash closspray or use perine urethra and work ou penis, scrotum, inner reposition and wash Skin Program policy Indicated to ensure facility without press pressure ulcers unle condition demonstration unavoidable. on ad of skin status done further comprehense done with readmiss condition or surface assessment will be is identified. 483.25(e)(1)-(3) NC RESTORE BLADDI (e) Incontinence. (1) The facility must continent of bladder receives services a continence unless h or becomes such th to maintain. (2)For a resident wio facility must ensure (i) A resident who e indwelling catheter	if stool present use perineal oth and apply skin cleansing al wipes, wash starting with utward, retract foreskin, wash er thighs, gently pat dry. h rectal area. y dated 9/2016: a resident who enters the sure ulcers does not develop ess the individuals clinical ates that they were dmission, baseline assessment e within 2 hours of admission. sive skin assessments will be sion, annually, and change of e comprehensive wound completed when a skin ulcer D CATHETER, PREVENT UTI, ER t ensure that resident who is r and bowel on admission nd assistance to maintain his or her clinical condition is hat continence is not possible ith urinary incontinence, based omprehensive assessment, the e that-		314			8/31/17

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245223	B. WING	÷		07/	28/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
					1412 WEST FOURTH STREET		
RED WIN	IG HEALTH CENTER				RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 44	F	315	5		
	indwelling catheter is assessed for rem as possible unless demonstrates that o and	enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary					
	receives appropriat	e treatment and services to tinfections and to restore					
	on the resident's cc facility must ensure incontinent of bowe treatment and servi bowel function as p	with fecal incontinence, based omprehensive assessment, the that a resident who is I receives appropriate ces to restore as much normal ossible. NT is not met as evidenced					
	Based on observat review, the facility fa cares/services to pr	ion, interview and document ailed to provide necessary revent urinary tract infections idents (R64, R125) reviewed			F315 Incontinence Care Immediate corrective action: Catheter care was provided to res 64 as soon as the discrepancy wa identified. Resident #125 cathete and bag were repositioned up fror Action as it applies to others:	s ^r tubing	
	R64 was admitted to to the admission sh record indicate R64 urinary obstruction, completely empty th accumulation of flui phimosis (an inabili the penis) and a uri	o the facility 8/18/15 according beet. Review of the medical to have current diagnoses of urinary retention (inability to be bladder), hydrocele (an d around the testicles), ty to retract the foreskin over nary tract infection (UTI).			The Policy and Procedure for Urir Catheter Care was reviewed and current. All residents with catheters will be assessed to assure catheter care identified on Care Plan and Care and added to Tx Sheets for nurse validate completion Catheter care competencies will b conducted on all nursing staff by 8/31/17 (date). This	remains is Card s to e	

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DAT	0938-039
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	IPLETED
		245223	B. WING		07/	28/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RED WI	NG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 315	R64 was in bed wit unsnapped and the bag uncovered and At 8:12 a.m. nursin room to assist with provide pericare or partial bath. NA-J a while holding cathe bladder. When interviewed, no training at the fa catheter care and i nursing assistant c was unaware of the below the bladder I reentering into the any training in cath During an interview licensed practical m to find providing ca sheet for R64 and provided. An interview with re 7/28/17, at 8:34 a.m access to the plan catheter care is del nurse is responsibl Document review f urology dated 1/17/ complete pericare f from the medical d resident had becom	age 45 h the catheter bag cover e lower quarter of the catheter d in direct contact with the floor. g assistant (NA)-J entered the morning care and did not catheter care during the assisted R64 to wheelchair eter bag above resident NA-J stated she had received acility related to the provision of t was briefly taught during her ourse the previous fall. NA-J e need to keep catheter bag evel to prevent urine from bladder. NA-J unable to recall eter cleaning instruction. / on 7/26/17, at 1:57 p.m. with hurse (LPN)-A, she was unable theter care on the treatment unable to state if it was being egistered nurse (RN)-A on m. revealed that NAs have of care and that providing legated to the NAs and the e to see that it is done. or R64 including a note from /17, directed staff to "please for pt [patient/R64]!" A note octor, indicated on 7/20/17, ne more somnolent and less rrent care plan included catheter bag below the ction related to providing	F 31	5 include proper positioning of tubags. Date of completion:8/31/17_ Recurrence will be prevented by Visual audits of catheter care to tubing and bag placement will be conducted on residents week to assure the procedure is bein completed according to Care P results of these audits will be s the facility QAPI committee for the need to increase, decrease discontinue the audits. The correction will be monitore DON/Designee	y: o include be ly x90 days g lan. The hared with input on e or	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245223	B. WING	;		07/	28/2017
NAME OF I	PROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	NG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	catheter care. R125's Minimum Diindicated R125 had impairment, a diagr cancer and an indw Care Plan dated 5/4 assistance with urinhaving an indwelling Medical doctor (MD identified R125 had severe, and he is urinhaving an indwelling Medical doctor Ord antibiotics for a UTI another UTI from 5. Observation on 7/2 lying in bed sleeping tubing running down bag was in a blue of floor in front of the B On 7/25/17, at 10:1 wheelchair in his ro on the floor as R12 forward and was ru with the wheel chair On 7/26/17, at 8:39 sleeping in bed with the bed and cathete side of wheelchairs On 7/27/17, at 7:10 wheeling self in who	 Pata Set (MDS) dated 5/4/17, d moderate cognitive nosis of malignant bladder velling Foley catheter. 4/17, identified R125 needed hary function related to R125 g Foley catheter. b) progress note dated 6/16/17, d Alzheimer's dementia. This is nable to make his own ders identified R125 was on l from 5/13 -5/23/17, and d/31/17 - 6/7/17. 4/17, at 3:30 p.m., R125 was g with the Foley catheter n his left leg and the catheter cloth bag lying directly on the bed. 9 a.m., R125 was sitting in his pom with the catheter bag lying to wheel self unning over the catheter tubing r tire. 9 a.m., R125 observed to be n wheelchair parked in front of er bag still connected to left 	F	315			

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		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245223	B. WING	;		07/	28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
RED WIN	IG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	wheelchair. Dark ye pooled in the bottor dragging on the floor Interview on 7/27/11 assistant (NA)-E sta catheter bag on the wheelchair because further stated she d backflow into R1255 was not positioned therefore putting R2 a UTI. On 7/27/17, at 8:12 wheeling self to din hanging off the whe urinary tubing was of floor, R125 was run this surveyor notifie this time RN-D state to drain with his cat side of his arm rest further stated, "I do just want to get him eat." During interview on of nursing (DON) we be to have the resid hanging below the I drainage of urine ar A policy, "Urinary C revised November 2	side of his armrest of his ellow urine is noted to be n of the catheter tubing that is	F	315	,		
	the catheter and to	keep the catheter and tubing urinary drainage bag must be					

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245223	B. WING _		07/	28/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
RED WIN	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 315	Continued From pa	ge 48	F 31	5		
		ower than the bladder at all e urine in the tubing and				
	bladder. Infection (flowing back into the urinary Control identifies, be sure the drainage bag are kept off the				
F 318 SS=D	483.25(c)(2)(3) INC DECREASE IN RA		F 31	8		8/31/17
	(c) Mobility.					
	receives appropriat	imited range of motion e treatment and services to notion and/or to prevent further of motion.				
	appropriate service to maintain or impro- practicable indeper mobility is demonst	imited mobility receives s, equipment, and assistance ove mobility with the maximum idence unless a reduction in rably unavoidable. NT is not met as evidenced				
	Based on interview facility failed to mai	and document review, the ntain range of motion (ROM) residents (R2) to prevent range of motion.		F 318 ROM Immediate corrective action: Resident # 2 was provided R Plan as soon as omission wa Action as it applies to others	OM per Care as identified.	
	Findings include:			The Policy and Procedure fo ROM remains current.		
	6/21/17 identified R injury and functiona limitation in ROM is lower extremities re	num Data Set (MDS), dated 22 diagnoses of intracranial al quadriplegia. R2 functional 5 impaired on both upper and 6 equiring R2 to be total for transfers and requires		All residents will be assessed who need assisted ROM hav identified and Care Planned. All nursing staff will be in-ser need to provide ROM per Ca Card. Date of completion:	ve been viced on the	

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	T OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTI	PLE CONSTRUCTION		. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				IPLETED
		245223	B. WING			/28/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
RED WII	NG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 318	memory score (BIN score of 14 indicati Record review of d kardex report (a rep review on compute identified nursing re one to provide pass lower extremity 15 Interview on 7/26/1 regarding therapy s she receives therap R2 is she was com stated, "Nope, I wa her call light on. R2's nursing progre refusal or indication completed for the p Interview on 7/26/1 assistant (NA)-B. S resident and requir positioning but can in bed. Interview on 7/27/1 stated R2 is deper in bed. NA also add not have pain and o Interview on 7/27/1 nursing (DON) stat ROM was in Point o program where NA the computer when the surveyor, which	AS) dated 6/21/17 identified a ng intact cognition ocument titled visual/bedside port nursing assistants can r of cares for the residents.) ehab/restorative staff assist of sive ROM to left upper and reps per joint 3 times week. 7 at 12:29 p.m. with R2 she receives, when asked if by she stated, "Nope." Asked fortable in her chair she nt to lay down," and pushed ess notes identified no notes of n why passive ROM was not bast six months. 7 at 12:47 p.m. with nursing Stated she is familiar with the ess a lot of assistance with help assist to role side to side 7 at 11:33 a.m. with NA-F indent on staff, but can help roll ded when positioning, R2 does	F 31	8 Recurrence will be prever Visual audits will be condi- residents weekly x90 day ROM is occurring per Car Card. The results of thes shared monthly with the fa- committee for input on the increase, decrease or dis audits. The correction will be mo- DON/Designee	ucted on 3 /s to assure re Plan/Care e audits will be acility QAPI e need to continue the	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/;	28/2017
NAME OF PROV	VIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WING F	HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 SS=E F 431 SS=E F 431 SS=E F 431 C Th dru the sa SS=E C PO on fac the aic an rec PO nu res sa Nu vil res sa S S (a) (a)	spect her staff to d fusal so staff can f ompleted or a char pllow up on 7/27/17 rifying no docume fusal or additional ceived the ROM. If DC a look back of n 7/10/17 ROM wa cility has a restora e ROM services. de is pulled to the nd not able to com quired the service plicy review dated ursing program rea- sident restorative nd documented qu urse manager in p Il include analysis sults, need for any me or discontinue 3.45(b)(2)(3)(g)(h ABEL/STORE DRU ne facility must pro- ugs and biological em under an agree (83.70(g) of this pa- filicensed personne w permits, but only ipervision of a lice) Procedures. A fa-	ation of refusal but would ocument ROM even any further assessment can be nge. 7 at 1:01 p.m. from the DON entation found regarding the documents verifying R2 DON was able to print from 30 days which only identified as completed. DON stated the tive aide that would complete DON stated the restorative floor to care for the residents plete ROM for the those who s 1/14/14 titled restorative ads; documentation of progress will be assessed warterly by the Registered rogress notes. These notes of participating, goals, y alterations, to remain the e. DRUG RECORDS, UGS & BIOLOGICALS povide routine and emergency ls to its residents, or obtain ement described in art. The facility may permit el to administer drugs if State y under the general	F 3				8/31/17

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		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/2	28/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	that assure the acc dispensing, and adi biologicals) to meet (b) Service Consult employ or obtain th pharmacist who (2) Establishes a sy disposition of all con- detail to enable and (3) Determines that that an account of a maintained and per (g) Labeling of Drug Drugs and biologica labeled in accordan professional princip appropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance w the facility must sto locked compartmer controls, and permi have access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when	urate acquiring, receiving, ministering of all drugs and t the needs of each resident. ation. The facility must e services of a licensed ystem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and t drug records are in order and all controlled drugs is riodically reconciled. gs and Biologicals. als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when us and Biologicals. with State and Federal laws, re all drugs and biologicals in nts under proper temperature t only authorized personnel to	F 4	131			

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. (X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245223	B. WING		07/2	28/2017
AME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
	NG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 431	Continued From pa	age 52	F 43 ⁻	1		
	quantity stored is n be readily detected This REQUIREME by:	ninimal and a missing dose can l. NT is not met as evidenced				
	Based on observation, interview, and document review, the facility failed to maintain insulin medication for 5 of 5 residents (R135, R92, R8, R67, and R86) at a safe temperature for use in 1 of 3 medication refrigerators reviewed, failed to dispose of expired medications, and did not label short term medications with the date opened to determine when the medication would outdate.			F 431 Storage of Medication Immediate corrective action: The Insulin was moved from r identified and temperature wa Outdated/unlabeled medication were discarded Action as it applies to others: All medication refrigerators wa	s adjusted. ons identified	
	STORAGE OF INS TEMPERATURE S During the initial to room on 7/24/17, a refrigerator thermo 29 degrees Fahrer practical nurse (LP temperature log pr used to be posted but had not seen o	-		Education also included the n medications when opened an process for checking medcart	rviced on icy which or ators, log, and mperature is ntified on the (date). eed to date d the	
	medication room o refrigerator temper LPN-D confirmed a insulin pens labele R86, and 2 unoper emergency kit (e-k present. LPN-D sta	a.m. during a review of n 3 West, LPN-D noted the rature read 27 degrees F. a count of thirty six unopened d for R135, R92, R8, R67, ned vials of insulin from the it). No temperature log ated that she had previously rator log but had not received		medications. Date of completion: 8/31/17 Recurrence will be prevented All medication refrigerators wi checked weekly to assure ter are maintaining the range ide logs are current and accurate medcarts will be checked wee dating when opened and for e medications. This audit will c	by: II be mperatures ntified and . All ekly for expired	

Facility ID: 00149

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY IPLETED
		245223	B. WING_			07/	28/2017
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
RED WII	NG HEALTH CENTER				12 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 431	temperature read 3 temperature. No te During an interview Director of Nursing temperature variation On 7/28/17, at 9:08 refrigerator temperation log present. On 7/28/17, at 9:23 stated per manufact be kept at a temperature degrees F. and the temperature log for refrigerator. On 7/28/17, at 11:1 using surveyor digit comparison with far 40 F a the same tim been removed from The facility's Medic 2016, indicates the range is between 3 tracking sheets for temperatures, and record temperatures EXPIRED MEDICA During an audit of t on 7/24/17, at 1:49 beneprotein with a the treatment cart	 44 degrees F. LPN-D verified mperature log present. 47 on 7/27/17, at 5:17 p.m. (DON) notified of refrigerator ons and stored insulin. 48 a.m. LPN-C verified ature reads 39 F. Temperature 49 a.m. Pharmacy Consultant cturer (Sanofi) insulin should rature no lower than 36 facility should keep a the medication room 48 a.m. Temperature taken tal thermometer read 41.5 F in cility thermometer reading of ne. Noted all the Insulin had in the refrigerator. 41 ation Storage policy, June refrigerator temperature 6-38 degrees F., monthly all refrigerators to record nursing staff will check and es daily. 	F 4:	31	increase, decrease or discontinue audits. The correction will be monitored to DON/Designee		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/21/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	e survey IPleted
		245223	B. WING			07/	28/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431	While auditing the r 7/24/17/at 5:52 p.m noted. Expiration d verified by LPN-A. During an audit of m 7/26/17 at 11:30 a.r expiration date 7/8/ expiration date 7/20 expiration date 7/20 nurse (RN)-B. LACKED OPEN DA CORRECT OUTDA During an audit of th LPN-C verified a via and had no opened which was open has bottle of Flonase the on date. During an interview responsibility for ch expiration dates. R	Are TO DETERMINE ATE to	F 4	.31			
F 441 SS=D	revised on 1/17 indi outdated, or deterio are destroyed. 483.80(a)(1)(2)(4)(e PREVENT SPREA		F 4	41			8/31/17
		tion and control program. tablish an infection prevention					

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		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATI	E SURVEY PLETED
		245223	B. WING			07/	28/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	NG HEALTH CENTER				1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	and control program a minimum, the follo (1) A system for pre- investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin accepted national s implementation is P (2) Written standard for the program, wh limited to: (i) A system of surve possible communic before they can spr facility; (ii) When and to wh communicable dise reported; (iii) Standard and tra to be followed to pre- (iv) When and how resident; including to (A) The type and du depending upon the involved, and (B) A requirement th	n (IPCP) that must include, at owing elements: eventing, identifying, reporting, ontrolling infections and eases for all residents, staff, and other individuals under a contractual d upon the facility assessment og to §483.70(e) and following standards (facility assessment Phase 2); ds, policies, and procedures nich must include, but are not eillance designed to identify able diseases or infections read to other persons in the nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a	F 4	141			

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	SURVEY PLETED
		245223	B. WING			07/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 56	F 4	41			
	must prohibit emplo disease or infected	ces under which the facility byees with a communicable skin lesions from direct hts or their food, if direct t the disease; and					
		ne procedures to be followed direct resident contact.					
		cording incidents identified PCP and the corrective e facility.					
		nel must handle, store, port linens so as to prevent the					
	annual review of its program, as necess	The facility will conduct an IPCP and update their sary. NT is not met as evidenced					
	Based on observat review, the facility fa hygiene procedures	tion, interview, and document ailed to ensure proper hand s were followed by staff for 1 of served receiving morning care ad of infection.			F 441 Infection Control Immediate corrective action: NAR-J was re-educated and handwa immediatley. Action as it applies to others: The Policy and Procedure for	ashing	
	Findings include:				handwashing remains current. All nursing staff will be re-educated		
	when nursing assis hands after providir included using wipe incontinent of stool.	erved on 7/26/17, at 8:39 a.m. tant (NA)-J failed to wash her ng morning cares which es as R64 had been . NA-J disposed R64's soiled g. NA-J removed her gloves			competencies completed for handwards on8/31/17(date). Date of completion: 8/31/17 Recurrence will be prevented by: Visual audits of handwashing practic		
	and left R64's room	a, taking the bag containing the ad not washed her hands			when indicated will be conducted 3x weekly x90 days on various Units.		

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PRINTED: 08/21/2017

					OMB NO	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245223	B. WING		07/	28/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 441	Continued From pa	ge 57	F 44 ²	1		
	a.m. NA-J was obs resident's room app uncovered resident would like to get up gloves in the room,	R64 and immediately at 8:40 erved going into another proached the bedside, and asked the resident if she for breakfast. NA-J donned then stated "let me get the esident's room and retrieved		Results will be shared with the fa QAPI committee for input on the increase, decrease or discontinu- audits. The correction will be monitored DON/Designee	need to le the	
	was asked about had not washed he and doing peri care	ed to the resident's room, she andwashing. NA-J verified she r hands after removing gloves for R64. NA-J stated I usually g desk after cares and wash nervous today.				
F 456 SS=B	Handwashing/Hygid their hands for at le before and after as care and after hand	cility policy dated 10/14 entitled ene, employees must wash east twenty (20) seconds sisting a resident with personal fling soiled or used linens. SENTIAL EQUIPMENT, SAFE DITION	F 456	6		8/31/17
		nechanical, electrical, and nent in safe operating				
	for adequate nursir residents. This REQUIREMEI	s ust be designed and equipped ng care, comfort, and privacy of NT is not met as evidenced				
	review, the facility f	tion, interview and document ailed to ensure 1 of 1 residents vheelchair armrest had		F 456 Maintenance Immediate corrective action: The W/C arm and strap for resid	lent #2	

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		AND HUMAN SERVICES			F	FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(3) DATE	SURVEY PLETED
		245223	B. WING			07/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E JE	(X5) COMPLETION DATE
F 456	Continued From pa	ge 58	F 4	56			
	Findings include:				Action as it applies to others: The preventive maintenance program current.	ı is	
	 12:29 p.m. the right wheelchair were no with exposure to the of the foot straps w down towards the fl facility offered to fix stated, "Nope!" R2 care plan reads mobility." The intervious for unpleasant odor wheelchair cushion needed. During an interview registered nurse (R to be fixed or replace maintenance depart program called "TE Interview on 7/27/1" 	7 at 12:54 p.m. with director of			All staff will be educated on the need t identify and report any equipment repar- needed promptly. The ID Team will be re-educated on the need to identify and report equipment repair needs during daily rounding. Date of completion: 8/31/17 Recurrence will be prevented by: Daily rounds will occur 5x weekly to review environmental concerns includ resident equipment. The results of the rounds will be discussed at the Quality Conference and Quality Wrap-up meetings. This will be an ongoing process with results shared monthly a facility QAPI committee. The correction will be monitored by: Administrator/Maintenance Director	bairs he t ding hese ty	
	wheelchair because attempt can void th manufacturer. R2 is wheelchair on a dai expectation of staff damage to the whe Interview with DON which the DON sup audits completed for resident equipment and verified there w	ed the facility cannot fix R2 e hers is custom and if they e warranty of the s placed in her custom ily basis. DON stated her would have reported the elchair maker before now. on 7/27/17 at 2:19 p.m. in oplied the surveyors with daily or each room including to DON reviewed the audits vas no documentation, which ed R2 damage to the					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		X3) DATE	SURVEY PLETED
		245223	B. WING		07/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	G HEALTH CENTER			412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 456	Continued From pa wheelchair.	ge 59	F 456			
	a.m. stated each wi identify areas that n	nistrator on 7/28/17 at 9:38 ing is gone through daily to need addressed. Administrator air should been identified r daily rounds.				
F 465 SS=B	equipment was required 483.90(i)(5)	e maintenance of resident uested, but not supplied. NL/SANITARY/COMFORTABL	F 465			8/31/17
	(i) Other Environme	ental Conditions				
		ovide a safe, functional, ortable environment for the public.				
	applicable Federal, regulations, regardi and smoking safety non-smoking reside This REQUIREMEN by:	NT is not met as evidenced				
	review, the facility fa environment that wa repair for 5 of 89 re (R86) rooms with le	ion, interview and document ailed to ensure an as clean, sanitary and in good sident rooms, 1 of 1 resident eaking bathroom ceiling and s, dining room and family		F 465 Maintenance Immediate corrective action: The areas identified on 200 and 300 areas of carpet loose/stained, peelin plaster, closet door room 20-2, hang cable, stained ceiling tiles, missing c tiles and dead insects will be repaired/replaced/removed.	ig Jing	
	Findings include:			Action as it applies to others: The preventive maintenance program	m is	
	i ne tollowing room	s and concerns were		current.		

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						0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245223	B. WING			28/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
	IG HEALTH CENTER			1412 WEST FOURTH STRE RED WING, MN 55066	ET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 465	Continued From pa	age 60	F 46	5		
	 7/28/17, at 8:30 a.r 2E8-2- bathroom c stains. 2E20-2-closet door against the wall. 2E44-2-TV cable h doorway. 3W61-During obse 7/26/17, at 10:50 a long tailed flying bu observed on the co dead ant on bathro floor, many dead g bedside stand and Observations durin the Administrator o revealed dead gna stand, large area o ceiling instead of co inches wide area th exposed pipes abor 	eiling tile with large brown f off the tracks and leaned anging down near the rvations of R86's room on .m., a live ant and dead green ligs called midges, were bunter between two closets, om sink, live ant on bathroom nats and dead midges on on the window sill. g the environment tour with n 7/28/17, at 8:30 a.m., ts (small flying bug) on bedside f hard plastic on bathroom eiling tile, with approximately 3 he length of the plastic that		All maintenance staff on the need to follow scheduled maintenan to include carpet, cei closet doors, and de Date of completion: 8/31/17 Recurrence will be p Daily rounds will occ review environmenta resident rooms and on needed repairs. The rounds will be discuss Conference and Qua meetings. This will be process with results facility QAPI committed The correction will be Administrator/Mainted	revented by: ad insect removal. revented by: ur 5x weekly to al concerns including common areas for e results of these ased at the Quality ality Wrap-up be an ongoing shared monthly at the tee. e monitored by:	
	water from the roof located next to the ceiling pipes were bugs on the bedsid pest control was at Document review of Report Form dated written concern of I A temporary fix was ago which included	of leak, the hose is draining into the wastebasket (which is toilet). Administrator verified visible. Administrator verified le stand. Administrator stated the facility every 30 days. of facility Grievance/Concern 3/15/17, revealed hand eak in R86's bathroom ceiling. s put into place several weeks a pipe draining into a bucket. ad been taken by the facility.				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245223	B. WING _		07/	28/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
RED WIN	G HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 465 F 520 SS=F	R86 to another room 3w68-2-3 bathroom covering door latch. 3w80-1-bathroom of 200 wing east tub ro 200 west wing carp 300 wing hallway ca 300 wing family lour ceiling stains. 300 wing dining roo plaster, brown stain 300 north wing-free thick dust. Although a policy w provided that addre building. During interview at 7/28/17, at 8:30 a.m areas of concern. H computer system to of needed repairs. I this every day. Fac meeting every morr department heads r rounds room check 483.75(g)(1)(i)-(iii)(2	rought up by the on taken was offered to move m, R86 refused to move. a tile with brown stains, tape dealing tile with brown stains. com-missing ceiling tile. et stained and loose in areas. arpets stained. nge peeling plaster, brown of doorway with peeling as on ceiling above doorway. e standing fan on 300 north hall as requested, none was assed maintenance of the the time of the tour on n., Administrator verified the He stated nurses use the o notify maintenance director Maintenance director checks illity has quality council ning and afternoon where report on their assigned s. 2)(i)(ii)(h)(i) QAA	F 46	55		8/31/17
	QUARTERLY/PLAN					

Facility ID: 00149

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		AND HUMAN SERVICES				FORM	08/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245223	B. WING			07/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				412 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From pa	ige 62	F 5	20			
		naintain a quality assessment nmittee consisting at a					
	(i) The director of n	ursing services;					
	(ii) The Medical Dire	ector or his/her designee;					
	staff, at least one of	er, a board member or other					
	(g)(2) The quality as committee must :	ssessment and assurance					
	coordinate and eva identifying issues w	arterly and as needed to luate activities such as vith respect to which quality ssurance activities are					
		plement appropriate plans of entified quality deficiencies;					
	Secretary may not i records of such cor such disclosure is r	formation. A State or the require disclosure of the mmittee except in so far as related to the compliance of th the requirements of this					
	committee to identit deficiencies will not sanctions.	I faith attempts by the fy and correct quality t be used as a basis for NT is not met as evidenced					

If continuation sheet Page 63 of 65

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION		0938-039 SURVEY	
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COM	PLETED	
		245223	B. WING _			07/2	28/2017	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	DE		
RED WIN	G HEALTH CENTER				12 WEST FOURTH STREET ED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 520	facility failed to ider failed to ensure the development and o facility policies and life and quality of ca following citations is with exit date of 8/5 residents currently Findings include: Refer to F225 as th allegations of emot residents (R104 an Refer to F226 as th operationalize the F Mistreatment, and I Property policy and environment that w residents (R104 an Refer to F282 as th qualified staff to cor residents (R62, R2, shaving, R2 for ran pressure ulcers, R6 for incontinence ca Refer to F318 as th follow up on missin 1 of 1 resident (R2) Refer to F441 as th	y and document review, the ntify quality concerns, and committee participated in versite of implementation of systems to ensure quality of are were maintained for the ssued on the previous survey 5/16 which affects 80 of 80 residing in the facility. The facility failed to report ional abuse for 2 of 3 d R27) in a timely manner. The facility failed to Prohibition of Abuse, Neglect, Misappropriation of Resident enforce a resident as free from abuse for 2 of 3 d R27). The facility failed provide mplete cares areas for 4 of 5 , R23 and R64). R62 for ge of motion, R23 for 54 for catheter care and R23 re. The facility failed to record and g range of motion services to	F 52	20	F 520 Immediate corrective action: The facility QAPI Committee will r review the areas identified in the f 2567 as soon as it is received and Action Plan will be developed. Action as it applies to others: The Facility QAPI Plan policy and procedure is current as to process The facility will enlist the assistant Corporate Quality Director to revie facility's QAPI Plan, meeting conte RCA, Action Plans, and follow-up. The ID Team will be re-educated of QAPI process by the Corporate Q Director on8/16/17(date Date of completion: 8/31/17 Recurrence will be prevented by: Weekly Audits of the Facility QAP Plan areas will be conducted by d members of the ID Team to assur progress and consistency is main These audits will be discussed mo the QAPI meeting and changes m according to outcomes. This will lo ongoing process. The correction will be monitored b Administrator/DON	acility an acility an acility acide withe ent, on the uality aciton fferent e ained. onthly at ade pe an		

If continuation sheet Page 64 of 65

		AND HUMAN SERVICES					FORM	08/21/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	FIPLE CONSTE				E SURVEY PLETED
		245223	B. WING				07/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CO	ODE		
RED WIN	IG HEALTH CENTER				T FOURTH STREET G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF COR EACH CORRECTIVE ACTION DSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 520	interviewed about t The administrator s meets monthly, and well, as how they w facility. The administ nursing and the administrator further head is responsible recognizes some h help guide them. T	heir quality assurance (QA). stated their QA committee d identified who attended as yould identify issues in the strator stated the director of ministrator oversee the he expectations. The er stated each department but ave different experiences and he administrator recognized encies and stated they still	F 5	20				

Facility ID: 00149

If continuation sheet Page 65 of 65

		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	5 22	3025		FORM	08/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		STRUCTION AIN BUILDING 01			E SURVEY PLETED
		245223	B. WING				07/2	27/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZI	P CODE		
	IG HEALTH CENTER							
				REDW	ING, MN 55066	CORRECTION	1	(NE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	КO	000				
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.						
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.						
	Minnesota Departm Fire Marshal Divisio (Red Wing Health (compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, Center) was found not in a requirements for participation and at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), a Health Care.						
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY			EDA			
	Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	Division Suite 145			EPU			
	By email to: Marian.Whitney@s	tate.mn.us and						
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE			(X6) DATE
Electron	ically Signed							08/18/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245223	B. WING		-6	07/2	27/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER				412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX T A G	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa Angela.Kappenmar	-	ĸ	000			
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	vhat has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	a partial basement. at 3 different times. constructed in 1965 Type II(222) constru- constructed to the V determined to be of 1999 a small addition wing. Because the addition are of the simeet the construction	enter is a 3-story building with The building was constructed The original building was and was determined to be of action. In 1972, addition was West Wing that was Type II(222) construction. In on was added to the west original building and the 2 same type of construction and on type allowed for existing y was surveyed as one					
	system. The facility full corridor smoke	ected by a full fire sprinkler has a fire alarm system with detection and spaces open to monitored for automatic fire tion.					
K 291	census of 80 at the	·	ĸ	291			9/11/17

Facility ID: 00149

If continuation sheet Page 2 of 9

	RS FOR MEDICARE			E CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01		PLETED
		245223	B. WING		07/2	27/2017
AME OF F	PROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER			412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 291 SS=F	Continued From pa	ige 2	K 291			
K 324 SS=D	is provided automa 18.2.9.1, 19.2.9.1 This STANDARD i Emergency Lighting is provided automa 18.2.9.1, 19.2.9.1 Findings Include: On facility tour betw on 7/27/2017, base and interview that t The Facility does n lighting testing mor This deficient pract all the residents, st facility. This deficient pract Facility Maintenanc discovery. NFPA 101 Cooking Cooking Facilities Cooking equipmen with NFPA 96, Star and Fire Protection Operations, unless	of at least 1-1/2-hour duration tically in accordance with 7.9. s not met as evidenced by: g of at least 1-1/2-hour duration tically in accordance with 7.9. veen 09:00 AM and 01:00 PM ed on documentation review he following include: ot have copy of emergency othly and annual test tice could affect the safety of aff and visitors within the ice was confirmed by the e Director at the time of Facilities t is protected in accordance odard for Ventilation Control of Commercial Cooking : g equipment (i.e., small	K 324	K 291 Emergency Lighting is tes monthly by facility Maintenance Department. Documentation of t will be recorded and maintained I Director of Maintenance. Docum will be reviewed by QAPI Commi 90 days. 09/11/17	esting by the entation	9/11/17

Facility ID: 00149

If continuation sheet Page 3 of 9

Contraction of the local distance of the loc						SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01		PLETED	
		245223	B. WING		07/27/2017		
AME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
	IG HEALTH CENTER		1412 WEST FOURTH STREET RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
K 324	or * cooking facilities i 30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities p per 9.2.3 are not re hazardous areas, b corridor.	under 18.3.2.5.3, 19.3.2.5.3, n smoke compartments with s comply with conditions under 5.4. rotected according to NFPA 96 quired to be enclosed as but shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through	K 324				
	Cooking Facilities Cooking equipment with NFPA 96, Stan and Fire Protection Operations, unless * residential cookin appliances such as toasters) are used cooking in accorda * cooking facilities of compartments with with the conditions or * cooking facilities if 30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities p per 9.2.3 are not re hazardous areas, b corridor.	g equipment (i.e., small microwaves, hot plates, for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, n smoke compartments with s comply with conditions under		K 324 Facility kitchen hood has beinspected. Documentation of the inspection shall be maintained annu the Director of Maintenance. The k hood inspection will be scheduled annually by the Maintenance Direct 09/11/17	ually by titchen		

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		& MEDICAID SERVICES	(X2) MULTE	LE CONSTRUCTION	(X3) DATE	SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01 B. WING		COMPLETED 07/27/2017		
		245223					
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	IG HEALTH CENTER		1412 WEST FOURTH STREET RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
K 324	Continued From pa Findings Include:	age 4	K 324	1			
	on 7/27/2017, base and interview that t	veen 09:00 AM and 01:00 PM ed on documentation review he following include: ot have a annual kitchen hood					
		ice could affect the safety of all and visitors within the facility.					
		ice was confirmed by the ce Director at the time of					
K 351		r System - Installation	K 35 ⁻	1		9/11/17	
SS=E	construction type, a approved automati accordance with N Installation of Sprir In Type I and II cor measures are pern sprinkler protection or local regulations In hospitals, sprink closets of patient s of the closet does n sprinkler coverage required by NFPA Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9	d hospitals where required by are protected throughout by an c sprinkler system in FPA 13, Standard for the ikler Systems. Instruction, alternative protection nitted to be substituted for in specific areas where state prohibit sprinklers. lers are not required in clothes leeping rooms where the area not exceed 6 square feet and covers the closet footprint as 13, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5,					

Facility ID: 00149

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	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245223	B. WING		07/	27/2047
	PROVIDER OR SUPPLIER			IREET ADDRESS, CITY, STATE, ZIP CODE	1 077	27/2017
	-ROVIDER OR SUFFLIER			12 WEST FOURTH STREET		
	IG HEALTH CENTER		RED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 351	Continued From pa	age 5	K 351			
	Nursing homes, ar construction type, a approved automati accordance with N Installation of Sprin In Type I and II cor measures are perr sprinkler protection or local regulations In hospitals, sprink closets of patient s of the closet does sprinkler coverage required by NFPA Sprinkler Systems	nd hospitals where required by are protected throughout by an ic sprinkler system in FPA 13, Standard for the hkler Systems. Instruction, alternative protection mitted to be substituted for in specific areas where state is prohibit sprinklers. Iters are not required in clothes bleeping rooms where the area not exceed 6 square feet and covers the closet footprint as 13, Standard for Installation of		facility Maintenance Director shall responsible for ceiling tile installat Ceiling tile inspection will be part routine rounds of the building by Maintenance Director. 09/11/17	tion.	
	on 7/27/2017, base revealed that the f	g ceiling tiles in room 20 a				
		room 1043. tice could affect the safety of all and visitors within the smoke				
K 372	Facility Maintenand discovery.	tice was confirmed by the ce Director at the time of sion of Building Spaces -	K 372			9/11/17
	Smoke Barrie					
	Subdivision of Buil Construction	ding Spaces - Smoke Barrier				

		& MEDICAID SERVICES			MB NO.	SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01		PLETED
		245223	B, WING		07/27/2017	
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IG HEALTH CENTER			1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
К 372	fire resistance ratin be permitted to term Smoke dampers all penetrations in fully an approved sprink smoke compartme barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This STANDARD Subdivision of Buil Construction 2012 EXISTING Smoke barriers sha fire resistance ratin shall be permitted to Smoke dampers all penetrations in fully an approved sprink smoke compartme barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. Findings Include: On facility tour betwon 7/27/2017, base revealed that the for We found penetrat smoke barrier on 2 This deficient pract	all be constructed to a 1/2-hour ig per 8.5. Smoke barriers shall minate at an atrium wall. re not required in duct / ducted HVAC systems where cler system is installed for nts adjacent to the smoke manical smoke control system is not met as evidenced by: Iding Spaces - Smoke Barrier all be constructed to a 1/2-hour ng per 8.5. Smoke barriers to terminate at an atrium wall. re not required in duct / ducted HVAC systems where cler system is installed for nts adjacent to the smoke manical smoke control system ween 09:00 AM and 01:00 PM ed on observation and interview ollowing include: ions above ceiling in the	K 372		d floors oonsible s	

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	01 - MAIN BUILDING 01		PLETED	
		245223	B. WING		07/2	27/2017	
AME OF F	PROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CODE			
	IG HEALTH CENTER		1412 WEST FOURTH STREET RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE	
K 372	Continued From pa	age 7	K 372				
		tice was confirmed by the ce Director at the time of					
K 521	NFPA 101 HVAC		K 521			9/11/17	
SS=F	HVAC						
	Heating, ventilation						
	HVAC Heating, ventilation	is not met as evidenced by: n, and air conditioning shall d shall be installed in		K 521 Please see attached waiver. 08/17/2017	·		
	accordance with th specifications.	e manufacturer's		Red Wing Health Center requests a waiver for the K521. The facility is			
	18.5.2.1, 19.5.2.1, Findings Include:	9.2		documented to be fully sprinklered has auto shutoff of the HVAC syste Additionally, evidence that correctiv	m. ⁄e		
		ween 09:00 AM and 01:00 PM on observation and interview ollowing include:		action would pose an unreasonable hardship on the facility. Cost to imp HVAC system would cost approxim \$530,000. It is also estimated that work would disrupt the normal use	orove ately such of		
	floors in the 1965 a	tem on the 1st, 2nd, and 3rd addition utilizes the egress Irn air for the resident rooms.		patient areas for at least 6 months.			
		tice could affect the safety of all and visitors within the this					

If continuation sheet Page 8 of 9

		AND HUMAN SERVICES			FORM	: 08/23/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DA COI	TE SURVEY MPLETED
		245223	B, WING		07	/27/2017
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP		
	IG HEALTH CENTER		1412 WEST FOURTH STREET RED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
K 521	Continued From pa Facility Maintenanc discovery.	ge 8 le Director at the time of	K 52			
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 5Z1	<21	Facility ID: 00149	If continuation sh	eet Page 9 of 9



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 11, 2017

Mr. Dennis Decosta, Administrator Red Wing Health Center 1412 West Fourth Street Red Wing, MN 55066

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5223027

Dear Mr. Decosta:

The above facility was surveyed on July 24, 2017 through July 28, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Red Wing Health Center August 11, 2017 Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731 or at gary.nederhoff@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

Minnesc	ta Department of He	alth			I OI WI	AT TROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY PLETED
		00149	B. WING		07/2	28/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	IG HEALTH CENTER		G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf elicensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 08/21/17

Electronically Signed

6899

If continuation sheet 1 of 56

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00149	B. WING	B. WING		28/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
	NG HEALTH CENTER		ST FOURTH S IG, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 000	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, th corrected prior to el Minnesota Departm On July 24, 25, 26, this Department's s and the following co Please indicate in y correction that you and identify the data Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled " II statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow are the Suggested Time period for Cor	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 27, & 28, 2017, surveyors of taff visited the above provider prection orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. The they been so a state statutes/rules for umber appears in the far left D Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and trection.				
	FOURTH COLUMN "PROVIDER'S PLA	N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 07/28/2017	
		00149				
IAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 000	Continued From pa	age 2	2 000		·	
	PLAN OF CORRE	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF TE STATUTES/RULES.				
2 255	MN Rule 4658.007 Assurance Commi	0 Quality Assessment and ttee	2 255			8/31/17
	assessment and a of the administrato services, the medic designated by the three other member representing discip resident care. The assurance commit respect to which qui necessary and dev appropriate plans of quality deficiencies address, at a minir	ust maintain a quality ssurance committee consisting r, the director of nursing cal director or other physician medical director, and at least ers of the nursing home's staff, blines directly involved in a quality assessment and tee must identify issues with uality assurance activities are relop and implement of action to correct identified a. The committee must num, incident and accident control, and medications and a.				
	by: Based on interview facility failed to iden failed to ensure the development and of facility policies and life and quality of c following citations is with exit date of 8/5	and document review, the ntify quality concerns, and e committee participated in oversite of implementation of systems to ensure quality of are were maintained for the ssued on the previous survey 5/16 which affects 80 of 80 residing in the facility.		see POC		
	Findings include:					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
RED WING HEALTH CENTER 1412 WEST FOURTH STREET RED WING, MN 55066							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 255	Continued From pa	ge 3	2 255				
	allegations of emot	e facility failed to report ional abuse for 2 of 3 d R27) in a timely manner.					
	Mistreatment, and I Property policy and	Prohibition of Abuse, Neglect, Misappropriation of Resident enforce a resident as free from abuse for 2 of 3					
	qualified staff to col residents (R62, R2 shaving, R2 for ran	e facility failed provide mplete cares areas for 4 of 5 , R23 and R64). R62 for ge of motion, R23 for 64 for catheter care and R23 re.					
		e facility failed to record and g range of motion services to					
		e facility staff had not shing in between cares of					
	interviewed about the The administrator somets monthly, and well, as how they we facility. The administ nursing and the administ program and sets the	5 a.m. The administrator was heir quality assurance (QA). stated their QA committee d identified who attended as rould identify issues in the strator stated the director of ministrator oversee the he expectations. The					
	head is responsible recognizes some h help guide them. Tl	er stated each department e for their department but ave different experiences and he administrator recognized encies and stated they still do.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED	
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	G HEALTH CENTER						
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2 255	Continued From page	ge 4	2 255				
2 565	The director of nurs review and revise p to ensuring the care resident is followed. designee could dev and develop a moni are providing care a of care. TIME PERIOD FOF (21) days. MN Rule 4658.0405	HOD OF CORRECTION: ing (DON) or designee could olicies and procedures related a plan for each individual . The director of nursing or elop a system to educate staff itoring system to ensure staff as directed by the written plan R CORRECTION: Twenty-one 5 Subp. 3 Comprehensive				8/31/17	
	Plan of Care; Use Subp. 3. Use. A co	omprehensive plan of care personnel involved in the					
	by: Based on observation review, the facility far of 1 resident (R62 assistance with person provide range of mo 1 resident (R2) accord and failed to follow	ent is not met as evidenced on, interview, and record ailed to follow the care plan for 2) assessed to need extensive sonal hygiene. Also failed to otion (ROM) exercises for 1 of ording to their plan of care, the care plan for 1 of 1 h pressure ulcers and		see POC			
	-	a Set (MDS) dated 5/2/17,					

STATEMEN	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00149	B. WING		07/20/2017	
					07/28/2017	
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST ST FOURTH S			
	IG HEALTH CENTER		NG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPL THE APPROPRIATE DAT	
2 565	Continued From pa	age 5	2 565			
		severe cognitive impairment sive assist of 1 with personal				
		ted 6/25/15, identified R63 with assistance with shaving or s upon discovery.	1			
	grooming needs as	d 7/27/17, identified R63's ssist with shaving or pluck covery per R63's wishes.				
	was sitting on the or during a scheduled noted to have seve During subsequent 9:35 a.m., 7/26/17,	on 7/24/17, at 4:07 p.m., R63 couch in the common area I singing activity and R63 was eral long unshaven chin hairs. t observations on 7/25/17, at at 12:53 a.m., and on 7/27/17 continued to have long, rs.	,			
	assistant (NA)-B ve had facial hair shav	n 7/26/17, at 1:52 p.m., nursing erified that R63 should have ved. Further stated R63 does personal shaver to be shaved.				
	verifies that R63 ne with shaving per th	on 7/26/17, at 1:57 p.m., NA-C eeds extensive assist to help e care plan and that R63 er chin hairs shaved.				
	registered nurse (F have had her chin	n 7/27/17, at 7:48 a.m., RN)-D verified that R63 should hairs shaved and stated, "This ing in a nursing home and to al hairs."				
	nursing (DON) veri	7, at 8:51 a.m., director of fied her expectation is to ht as needed and to follow the				

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2 565	care plan as directe	ed. DON further stated they	2 565			
	would contact social services to get R63 a personal shaver. R2's quarterly Minimum Data Set (MDS), dated 6/21/17 identified R2 diagnoses of intracranial injury and functional quadriplegia. R2 functional limitation in ROM is impaired on both upper and lower extremities requiring R2 to be total dependent on staff for transfers and requires extensive assistance for bed mobility, dressing and personal hygiene.					
	(a report nursing as computer of cares f nursing rehab/resto provide passive RC	ne visual/bedside kardex report ssistants can review on for the residents) identified prative staff assist of one to DM to left upper and lower tions (reps) per joint 3 times				
	motion. The care p for staff to perform extremity and left lo three times a week an intervention stat support R2 in her s and offer reassurar	ognizes limited range of lan also identified R2 the need passive ROM to left upper ower extremity 15 reps per joint R2 care plan also identifies ting staff acknowledge and struggle with her limited mobility nce and assistance so R2 can n active lifestyle per R2's				
	7/27/17 at 1:01 p.m received one day o days. No evidence ROM according to R23 was admitted t	verified in an interview on h. the resident had only f ROM services in the last 30 resident refused to do the care plan. to the facility on 7/14/16, y Admission Record.				
innosota D		Admission Record.				

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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	NG HEALTH CENTER		ST FOURTH S			
			G, MN 55066			
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2 565	Continued From pa	ge 7	2 565			
	neurogenic bowel, i bladder and seizure	, traumatic brain injury, neuromuscular dysfunction of es, according to facility note dated 7/25/17.				
	Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired decision making, totally dependent on two staff for activities of daily living which included bed mobility, transfers, dressing, toileting and hygiene, always incontinent of bowel and bladder, pain unable to answer, functional limitation in range of motion on both sides, unstageable pressure ulcer due to slough or eschar, pressure ulcer not present on prior assessment, feeding tube, tracheostomy, suctioning, oxygen.					
	for urinary incontine of staff for toileting bladder. Diagnosis	f R23's Care Area dated 7/3/17, had triggered ence due to totally dependent and always incontinent of of neurogenic bladder, has Staff assist every 2-2 ½ hours				
	on the right hip, pos incontinent of a larg	to have two pressure ulcers sitioned on the right hip, was ge amount of urine while laying did not receive perineal care nence.				
	included the followi Care plan problem bowels and bladder check incontinence minus 15 minutes a	re plan print dated 7/26/17, ng directions for staff: of always incontinent of r. Interventions included: e product every 2 hours plus or and as needed, change as otective skin care with each				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		E SURVEY PLETED
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2 565	Continued From pa	ige 8	2 565			
	incontinence episo	de.				
	Report (NA assignr directed to check ir hours plus/minus of needed, provide pro- incontinence. During observation 8:58 a.m., Nursing R23's incontinent b bed were wet. Obset the incontinent brie Observations at that provided R23 with a clean bedding. NA on the right buttock	of R23's Visual/Bedside Kardex ment sheet) revealed NA incontinence product every 2 15 minutes, change as otective skin care with each as on 7/26/17, at 8:30 a.m. to assistant (NA)-D checked rief and verified the brief and servations at that time revealed f was heavily saturated. at time revealed NA-D a clean incontinent brief and A-D stated R23 had a wound t. NA-D verified had not are before putting new resident.				
		17/26/17, at 10:30 a.m., LPN-E rineal care with each	3			
	director of nursing	7/26/17, at 12:01 p.m., (DON) stated she expected ded after each incontinence.				
	Policy-individual, re be initiated upon ac interdisciplinary tea	cy dated 11/2016 included, esident centered care planning dmission and maintain, by the im throughout the resident's timal quality of life while in				
	reads; resident cen maintained by the i	l 11/16 titled care planning itered care planning is nterdisciplinary team through iy to promote optimal quality of				

Minneso	ota Department of He	ealth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00149	B. WING		07/28/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	NG HEALTH CENTER		ST FOURTH S G, MN 55066			
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2 565	life, in doing so the made: each reside resident has a right life-patterns as able care planning and e highest practical ph through the nursing Care plans are acc and their responsib routinely of change SUGGESTED MET The director of nurs review and revise p to ensuring the care resident is followed designee could dev and develop a mon are providing care a of care.	following considerations are ent is an individual, each to be happy, continue their e, resident are included in encouraged to maintain their hysical and mental abilities to home stay. essible to all direct care staff illity to review the care plan	2 565			
2 570	Plan of Care; Revision Subp. 4. Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	5 Subp. 4 Comprehensive sion . A comprehensive plan of wed and revised by an im that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal or representative at least or seven days of the revision of resident assessment required	2 570			8/31/17

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00149	B. WING		07/	07/28/2017	
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	IG HEALTH CENTER		ST FOURTH IG, MN 5506				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
2 570	Continued From pa	ge 10	2 570				
	by part 4658.0400,	subpart 3, item B.					
	This MN Requireme	ent is not met as evidenced					
	Based on observati review, the facility fa was updated and of and prevent further	on, interview and document ailed to ensure a plan of care r revised to promote healing ulcers from developing for 1) who developed two pressure hip area.		see POC			
	Findings include:						
	according to facility R23 had diagnosis failure with hypoxia neurogenic bowel, i bladder and seizure physician progress Facility identified R2 Data Set (MDS), 4/- term memory proble decision making, to for activities of daily mobility, transfers, o hygiene, always inco pain unable to answ range of motion on pressure ulcer due ulcer not present or tube, tracheostomy The facility identifie dated 6/19/17, sam identified with no pa	that included acute respiratory , traumatic brain injury, neuromuscular dysfunction of es, according to facility note dated 7/25/17. 23 on the quarterly Minimum 4/17, to have short and long em, severely impaired tally dependent on two staff / living which included bed dressing, toileting and ontinent of bowel and bladder, ver, functional limitation in both sides, unstageable to slough or eschar, pressure n prior assessment, feeding , suctioning, oxygen. d R23 on the annual MDS e as 4/4/17 MDS, and was ain.					
	on the right hip, wa	to have two pressure ulcers s positioned on the right hip, t of a large amount of urine right hip.					

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00149	B. WING		07/28/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
RED WII	NG HEALTH CENTER		ST FOURTH S IG, MN 55066	TREET		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 570	Continued From pa	ge 11	2 570			
	following: R23 currently had a ischium (healed 4/7 pressure ulcers. Int relieving mattress of notify physician/nur worsens, follow elin reposition every 2-2 observe skin daily a Care plan problem bowels and bladder check incontinence minus 15 minutes a needed, provide pro incontinence episoo Although R23's care ulcer was healed or indication of two cu right hip and no stat these ulcers. During observations 8:58 a.m., R23 was side with a pillow to NA-D checked R23 the brief and bed w time revealed the in saturated. Observa NA-D provided R22 and clean bedding. repositioned every th had a wound on the During interview on verified R23's care pressure ulcer heal R23's care plan wa pressure ulcers re- area.	e plan indicated the pressure n 4/7/17, there was no rrent pressure ulcers on the ff direction to keep position off s on 7/26/17, at 8:30 a.m. to positioned slightly on right the back, facing the doorway. 's incontinent brief and verified ere wet. Observations at that noontinent brief was heavily tions at that time revealed 3 with a clean incontinent brief NA-D stated R23 was to be two hours. NA-D stated R23	r 1			

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2 570	Continued From pa	ge 12	2 570			
	according to the ca expected R23 was right side where the Care Planning polic Policy-individual, re be initiated upon ac interdisciplinary tea stay to promote opt residence. In doing considerations are #7-Care plans shou conferences to refle individual resident a information updated resident's care plan changes. Interdisci confer with each ot	sident centered care planning Imission and maintain, by the m throughout the resident's imal quality of life while in so, the following made: Id be updated between care ect current care needs of the as changes occur. Any d or discontinued in the will include the date of the plinary team members must her prior to changing wolve multiple departments to				
	The director of nurs policies and proced care plan for each i and revised. The d educate licensed st plans. The director monitoring system	HOD OF CORRECTION: sing could review and revise ures related to ensuring the ndividual resident is updated irector of nursing could aff to update and revise care of nursing could develop a to ensure staff are providing the written plan of care.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 895	MN Rule 4658.0525 Motion	5 Subp. 2.B Rehab - Range of	2 895			8/31/17
	Subp. 2. Range of					1

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
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RED WII	NG HEALTH CENTER		6T FOURTH G, MN 5506	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETI DATE
2 895	Continued From part through positioning implemented and m comprehensive resis of nursing services development of a n provides that: B. a resident with receives appropriate increase range of m decrease in range of This MN Requirement by: Based on interview facility failed to main exercises for 1 of 1 further decrease in Findings include: R2's quarterly Minin 6/21/17 identified R injury and functional limitation in ROM is lower extremities re dependent on staff extensive assistance and personal hygien memory score (BIN score of 14 indicatin Record review of do kardex report (a rep review on computer identified nursing re	ge 13 and range of motion must be haintained. Based on the ident assessment, the director must coordinate the ursing care plan which h a limited range of motion the treatment and services to notion and to prevent further of motion. ent is not met as evidenced and document review, the ntain range of motion (ROM) residents (R2) to prevent range of motion. num Data Set (MDS), dated 2 diagnoses of intracranial I quadriplegia. R2 functional impaired on both upper and equiring R2 to be total for transfers and requires the for bed mobility, dressing he. R2's brief interview IS) dated 6/21/17 identified a	2 895	see POC		

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	age 14	2 895			
2 895	regarding therapy s she receives therap R2 is she was com stated, "Nope, I wa her call light on. R2's nursing progre refusal or indication completed for the p Interview on 7/26/1 assistant (NA)-B. S resident and requir positioning but can in bed.	 7 at 12:29 p.m. with R2 she receives, when asked if by she stated, "Nope." Asked fortable in her chair she nt to lay down," and pushed ess notes identified no notes of why passive ROM was not bast six months. 7 at 12:47 p.m. with nursing Stated she is familiar with the es a lot of assistance with help assist to role side to side 7 at 11:33 a.m. with NA-F 				
	stated R2 is deper	ndent on staff, but can help roll ded when positioning, R2 does				
	nursing (DON) stat ROM was in Point program where NA the computer wher the surveyor, which in the last 30 days. verify the documen expect her staff to	7 at 12:26 p.m. with director of ed the documentation for the of Care (POC a computer 's document). DON verified in e to find the information with n identified one day of therapy DON stated would have to tation of refusal but would document ROM even any further assessment can be ange.	F			
	verifying no docum refusal or additiona received the ROM. POC a look back o	17 at 1:01 p.m. from the DON entation found regarding the I documents verifying R2 DON was able to print from f 30 days which only identified as completed. DON stated the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00149	B. WING		07/	07/28/2017	
IAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
	IG HEALTH CENTER		ST FOURTH S				
			IG, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 895	Continued From pa	ige 15	2 895				
	the ROM services. aide is pulled to the	ative aide that would complete DON stated the restorative floor to care for the residents applete ROM for the those who es					
	nursing program re resident restorative and documented qu Nurse manager in p will include analysis	d 1/14/14 titled restorative ads; documentation of progress will be assessed uarterly by the Registered progress notes. These notes of participating, goals, by alterations, to remain the e.					
	The administrator of program to provide residents. The DON on the program and procedures related The DON could more receive proper rang quality assurance a	THOD FOR CORRECTION: could implement a restorative range of motion services for N could provide staff training d implement policies and to range of motion services. onitor to assure residents ge of motion treatment. The and assessment committee re ongoing compliance					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			8/31/17	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which					
	A. a resident wh	o enters the nursing home					

STATE FORM

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If continuation sheet 16 of 56

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00149	B. WING		07/28/2	07/28/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE			
	G HEALTH CENTER		ST FOURTH	-			
(X4) ID	SUMMARY STA		IG, MN 5506	PROVIDER'S PLAN OF ((X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	OMPLE DATE	
2 900	Continued From pa	age 16	2 900				
	pressure sores unle condition demonstr authenticates, that B. a resident w receives necessar	ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and who has pressure sores y treatment and services to revent infection, and prevent veloping.					
	by: Based on observat review, the facility f interventions to pro	ent is not met as evidenced ion, interview and document failed to implement omote healing for 2 of 3 0) with pressure ulcers.		see POC			
	-	to the facility on 7/14/40					
		to the facility on 7/14/16, Admission Record.					
	diagnosis to include hypoxia, traumatic	cian notes dated 7/25/17 list of e acute respiratory failure with brain injury, neurogenic bowel, function of bladder and					
	Data Set (MDS), 4/ term memory probl decision making, to for activities of daily mobility, transfers, hygiene, always inc pain unable to answ range of motion on pressure ulcer due	23 on the quarterly Minimum (4/17, to have short and long lem, severely impaired otally dependent on two staff y living which included bed dressing, toileting and continent of bowel and bladder, wer, functional limitation in both sides, unstageable to slough or eschar, pressure n prior assessment, feeding					

STATEMEN	<pre>ita Department of He it of Deficiencies</pre>	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		00149	B. WING		07/	28/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ^Y	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 17	2 900			
	tube, tracheostomy	, suctioning, oxygen.				
	The facility identified R23 on the annual MDS dated 6/19/17, same as MDS dated 4/4/17, and was identified with no pain. Document review of R23's Tissue Tolerance an assessment to evaluate pressure to areas that include bony prominence and prolonged pressure which could cause damage to tissue. See the following: 3/28/17-no redness throughout evaluation, is on a pressure reducing mattress, reposition every 2-2 ½ hours. 4/28/17-no redness throughout evaluation, remain on 2-2 ½ hour reposition schedule. 6/2/17- no redness noted, is on a pressure reducing mattress, reposition every 2 -2 ½ hours. Document review of facility Braden Scale Assessment for Predicting Pressure Sore Risk dated 4/28/17, and 6/2/17, revealed R23 was at high risk for developing pressure sore, skin very moist; chair fast-ability to walk severely limited or non-existent; mobility very limited-makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently; friction and shear are a problem-requires moderate to maximum assistance moving, complete lifting without sliding against sheets is impossible, frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance, spasticity, contractures or agitation leads to almost constant friction.					
	Evaluation of Skin I dated 4/28/17, reve developing pressur	f facility Comprehensive Inspection and Risk Factors Paled R23 was at high risk for e sore; other risk factors				
nesota D ATE FORI	epartment of Health M		6899 5	Z1K11	If continuati	on sheet 18 d

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMF	SURVEY
		00149	B. WING		07/2	28/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH S IG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 18	2 900			
	required assist with medical devices su diagnosis if brain ir unstageable pressi centemeters (cm) I Analysis indicated pressure ulcer rela existing pressure ir mobility and incont mattress in place, n reposition every tw Document review of Evaluation of Skin dated 6/2//17, reve assessment, excep unstageable pressi 1.5 cm by 0.05 cm wound had worsen and deeper, contin daily, turn and repo wheelchair a coupl staff assist with tur wheelchair and with Document review of Assessment (CAA)	of facility Comprehensive Inspection and Risk Factors aled all areas same as 4/28/17 of the right gluteal fold ure ulcer measured 4 cm by depth. Analysis indicated R23 red since hospital stay, is large ue to do dressing changes osition every 2-2 ½ hours, up in e times a day and requires two ning and repositioning in h all mobility. of R23's Care Area) dated 7/3/17, revealed				
	dependent with be of bowel and bladd	ure ulcer related to totally d mobility, always incontinent ler, and had a pressure ulcer instageable. Required special elchair cushion.				
	revealed the follow R23 currently had a ischium (healed 4/7 pressure ulcers. In	are plan print dated 7/26/17, ing directions for staff: an unstageable area on right 7/17) and is at risk for more terventions included: pressure on bed, treatments as ordered,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00149	B. WING		07/	28/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	ATE, ZIP CODE		
	NG HEALTH CENTER		ST FOURTH S IG, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	notify physician/nur worsens, follow elin reposition every 2-2 observe skin daily a plan problem of alw bladder. Interventio incontinence produ 15 minutes and as provide protective s incontinence episod Document review o Report (a Nursing A sheet) revealed NA every 2-2.5 hours w unable to help at al in wheelchair every bowel and bladder, every 2 hours plus/ needed, provide pro- incontinence. The following obser dated 7/26/17 at 7:0 asleep in low bed, a R23 was positioned a pillow at the back the doorway. At 7:1 nurse (LPN)-B, enter the tube feeding an treatment. R23 rem	se practitioner if wound nination care plan, turn and 2.5 hours assist of 2 staff, and weekly with bathing. Care vays incontinent of bowels and ns included: check ct every 2 hours plus or minus needed, change as needed, skin care with each de. f R23's Visual/Bedside Kardex Assistant [NA] assignment directed to turn and reposition vith two staff assist, R23 is l, dependent on staff, off-load 2-2.5 hours, incontinent of check incontinence product minus 15 minutes, change as otective skin care with each rvations and interviews were 02 a.m. R23 was observed and fall mat on floor by bed. d slightly on the right side with . R23 was positioned facing 8 a.m., licensed practical ered R23's room, discontinued d started a nebulizer nained in the same position side facing the door. At 7:27				
	LPN-B entered R23 nebulizer treatment LPN-B verified had time. R23 was obse	s on 7/26/17, at 8:21 a.m., 3's room, discontinued the During interview at that time not repositioned R23 at that erved positioned slightly on the ow at the back. R23 was				

	NT OF DEFICIENCIES	CALL CALL CALL CALL CALL CALL CALL CALL	. ,		(X3) DATE SURVEY COMPLETED			
		00149	B. WING		07/2	28/2017		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PED WING HEALTH CENTER 1412 WEST FOURTH STREET								
	NG HEALTH CENTER		ST FOURTH S IG, MN 55066					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE		
2 900	Continued From pa	age 20	2 900					
	same position, slig door. At 8:45 a.m., side facing door wi a.m., LPN-B entered needed anything. L up in a while. R23 if the right side, facin nursing assistant (I Observation at that positioned slightly of back, facing the doo incontinent brief and were wet. Observation incontinent brief wat Observations at that provided R23 with clean bedding. No the visible areas of stated R23 was to hours. NA-D stated buttock. Observation right wound dressin 7/26/17, 2:00 a.m. NA-D verified R23 NA-D verified R23 NA-D verified had n incontinence. At 9:: know when R23 had checked for incontin nursing assistant (I left side, facing the back and between verified R23 had a At 9:24 a.m., NA-A R23's morning cares cares are done bet At 9:39 a.m., NA-G morning cares were	he doorway. At 8:30 a.m., htly on right side facing the same position, slightly on right th a pillow at the back. At 8:52 ed R23's room, asked if R23 PN-B explained would get R23 remained positioned slightly on g the door. At 8:58 a.m., NA)-D entered R23's room. time revealed R23 was on right side with a pillow to the orway. NA-D checked R23's d verified the brief and bed ations at that time revealed the as heavily saturated. at time revealed NA-D a clean incontinent brief and red areas were observed on right hip and back. NA-D be repositioned every two I R23 had a wound on the right on at that time revealed one ng with hand written date of During interview at that time, had a large urine incontinence not provided perineal care after 11 a.m., NA-D verified did not id last been repositioned or nence. At 9:12 a.m., NA-D and NA)-A, positioned R23 on the window, with pillows at the the legs. NA-D and NA-A wound on the right buttocks. stated NA-G had completed es. They stated all residents ween 7:00 a.m., and 8:00 a.m. is tated had not completed R23. NA-G stated R23's e completed by the night shift included washing, dressing,						

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	······		
		00149	B. WING		07/	28/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET						
	IG HEALTH CENTER	1412 WE	ST FOURTH S	TREET		
		RED WIN	IG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE ⁻ DATE
2 900	Continued From pa	age 21	2 900			
	R23 was reposition 8:30 a.m., by LPN- went to R23's room nebulizer treatment cares for R23 at the stated the facility do repositioning for R2 repositioning of R2 stated R23 would h between 6:00 a.m. LPN-B verified the of when R23 was n LPN-B verified the of when R23 was n LPN-B stated expe incontinence. At 11 registered nurse (F transfer R23 from v mechanical lift, rem on left side facing t provided wound ca Observations at tha dressings on the rig unstageable ulcer v drainage on the dre cleansed the woun medi-honey to the appeared approxim eschar in the center color. Review of the with dispense date to wound every eig wounds with foam positioned on the le pillows to the back	23. LPN-B stated expected 3 every two hours. LPN-B have been repositioned to 6:30 a.m., by the night shift. facility had no documentation epositioned. At 10:30 a.m., ected perineal care with each :04 a.m., NA-A, NA-G and RN)-A, were observed to wheel chair to bed with a noved slacks, and positioned the window while RN-A tre to the right hip wound. at time revealed two foam ght hip located near each ed the smaller foam dressing ed area located on the right hip emoved the larger foam ht hip to reveal one with a large amount of tan essing and foul odor. RN-A d with sterile water, applied white eschar. The wound nately 3 centimeters with white er, edges were dark pink in ne medi-honey pharmacy label of 7/25/16, revealed to apply ht hours. RN-A covered both dressings. R23 was eft side facing the window with and between the legs. RN-A red area was new. RN-A				

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED		
		00149	B. WING		07/2	28/2017		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE	07/28/20			
RED WI	NG HEALTH CENTER		ST FOURTH S ⁻ IG, MN 55066	TREET				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 900	staff nurses complex week. RN-A verified started on 7/25/17. issues with faxing of with pharmacy deliv verified medi-honey delivered for several had been notified of when ordered. RN for debridement of canceled due to iss nurse to go with R2 stated R23 was res 7/31/17, at 1:00 p.m as unstageable with is stage 4, and dres drainage. RN-A sta also have been soa incontinence. RN have wound dressif expected R23 to be from back to left si RN-A stated she wa on the right side, sa wound, and faced ti smaller red area on from facing door for right hip. RN-A state had appeared befor stated she expected incontinence. RN pressure ulcer had	ete wound care the rest of the d medi-honey treatment RN-A stated the facility had order to pharmacy and issues vering the medi-honey. RN-A d had been ordered but not al days. RN-A stated physician f not starting the medi-honey A stated R23 was scheduled the wound recently, was sue with transportation and no 3 to the appointment. RN-A cheduled for debridement on n. RN-A described the wound n eschar, outside eschar area using soaked with tan ted the foam dressing could ked with urine due to the large A stated it was usual for R23 to ng soaked. RN-A stated she e repositioned every two hours, de and back to back again. as aware R23 was positioned ame side as the right hip he doorway. RN-A stated the the right hip was probably r sometime, positioned on the ed the red area on right hip re and then goes away. RN-A d perineal care after each A verified the unstageable declined.		DEFICIENC	τ)			

STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE			
		00149	B. WING		07/2	28/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE				
		1412 WE	ST FOURTH S	TREET				
	IG HEALTH CENTER	RED WIN	IG, MN 55066					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)		
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				DEFICIENC	Y)			
2 900	Continued From pa	ae 23	2 900					
		3						
	The following obcor	vations and interviews were						
		vations and interviews were 15 a.m. R23 was in bed on left						
		low with a pillow to the back.						
		During interview at that time, LPN-B stated R23 was just repositioned and LPN-B would do						
	dressing change later. At 9:30 a.m., interview							
	5 5	IA)-H who stated R23 was to						
		ery two hours and checked for						
		two hours. NA-H stated had						
	-	had a wound on the right hip						
		was not to be positioned on						
	the right side. NA-H	I stated would provide pericare	e					
	after each incontine	ence. At 9:35 a.m., interview						
	nursing assistant (NA)-I stated R23 was to be							
	repositioned every	two hours and checked for						
	incontinence every	two hours. NA-I stated there is	6					
		ctions for care inside the						
		tated had cared for R23, who						
		e right hip and was not to be						
		ght side. NA-I stated would						
		er each incontinence. At						
		ations revealed NA-H						
		ne left side while RN-A						
		ng changes to the right						
		oved the smaller foam						
	0 0 1	to reveal red area which						
		2 cm, blanchable and no						
	. .	plied a foam dressing to the						
		noved larger right hip with tan drainage, wound						
		y 3.9 cm by 1.1 cm and 2 cm						
		depth, with 75 percent eschar per RN-A. RN-A cleansed the wound with sterile water, applied						
		vered the wound with a white						
	5	. RN-A and NA-H positioned						
		pillows between the legs.						
		view RN-A verified was aware						
	R23 had previously	been positioned on his right						
		been positioned on his right vound on the morning of						

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
			A. BUILDING.			
		00149	B. WING		07/2	28/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	IG HEALTH CENTER	1412 WE	ST FOURTH S	STREET		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE ⁻ DATE
2 900	Continued From pa	age 24	2 900			
	7/26/17. RN-A stated the night staff thought they were doing the right thing by placing R23 on the right side, off of left hip fracture.					
	with RN-A and dur the facility Weekly dated 6/19/17 to 7/ unstageable press During interview at right ischium woun was measured on and unstageable. If tissue tolerance ev a wound develops hospital. RN-A veri right ischium press was a different ulco plan was not revise found on 3/28/17. If hospitalized from 4 impaction. RN-A veri progress note iden fall prior to hospital determine if the frage	Wound Documentation Forms ring the review RN-A stated Wound Documentation Forms (24/17, which identified one ure ulcer on the right ischium. this time, RN-A verified the d was found on 3/28/17, and 3/31/17, to be 1 cm by 1 cm, RN-A stated she expected valuation completed whenever and with every return from the fied R23's care plan stated sure ulcer healed 4/7/17 which er. RN-A verified R23's care ed to include the new ulcer RN-A verified R23 was 4/23/17 to 4/28/17, with fecal erified the 5/4/17 physician tified a left hip fracture, had a lization, and very difficult to acture occurred at the nursing				
	dated 5/4/17, ident right ischial ulcerat hospitalization, app verified R23's care and bladder, direct each incontinent e skin care was the u incontinence. RN-	ed physician progress note ified one- stage 2 decubitus ion, found prior to pears to be worse. RN-A plan for incontinence of bowel red protective skin care with pisode. RN-A stated protective use of barrier cream after each A stated the care plan lacked e perineal care after				
	incontinence becau order of care, staff each incontinence. no way to identify w	use perineal care is a standard were expected to provide with RN-A verified the facility had when R23 was repositioned continence. RN-A stated R23				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED		
		00149	B. WING		07/	28/2017		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DED WING UEALTH CENTER 1412 WEST FOURTH STREET								
RED WIN	IG HEALTH CENTER		ST FOURTH S IG, MN 55066	TREET				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)		
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE		
2 900	Continued From page	ge 25	2 900					
	mav be drv all night	and then have a large						
		verified physician order dated						
		on every two hours, and						
		in directed reposition every						
		A verified physician order						
	dated 7/17/17, for medi-honey to the wound, and							
	verified the treatment did not start until 7/25/17							
	when the ointment arrived, a period of eight days							
		A stated staff made attempts						
		to obtain medi-honey. RN-A verified physician						
	progress note dated 7/25/17, in which the							
	physician identified R23's prior debridement was							
	canceled and physician ordered right hip x-ray.							
	RN-A stated the debridement was canceled due							
	to not having the right transportation, procedure							
		led a week later and canceled						
		able to go with R23. RN-A						
		x-ray was completed on n., and debridement was						
		17, at 1:00 p.m. RN-A verified						
		note 4/11/17, identified visit						
		ead laceration overnight and						
		re ulcer found on 3/28/17.						
		ly Wound Documentation						
		and progress note dated						
		ight ischial wound healed.						
		sustained a fall from bed on						
		laceration and was seen by						
		11/17. RN-A verified R23 was						
	hospitalized 4/23/17	7 to 4/28/17, for evaluation of						
	the left hip fracture.							
		icant change progress note						
		h identified a large red area						
		by 3 cm and inside the red						
		area measured 3 cm by 1 cm						
		per thigh crease. RN-A stated						
		e hospital on 4/23/17, for						
		o fracture. RN-A verified R23						
	developed right isch on 4/7/17, develope	nial ulcer on 3/28/17, healed						

Minnesota Department of Health STATE FORM

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00149	B. WING		07/2	28/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
	NG HEALTH CENTER		ST FOURTH S IG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 26	2 900			
		3 cm and 3 cm by 1 cm open, 3/17, and returned 4/28/17 ed.				
	Documentation For 3/31/17-pressure (u centimeter (cm) by drainage, no odor. analysis-wo current plan. treatm cream. 4/7/17-pressure rigu unstageable, no odo is healed. treatment-re 5/5/17- pressure rig 0.1 cm depth, unsta improved. analysis-on fracture, pressure rig 0.1 cm depth, unsta improved. analysis-on fracture, pressure rig 0.1 cm depth, unsta	ght ischium, 2 cm by 0.8 cm by ageable, no drainage, no odor, n bedrest related to hip				
	cover with foam da 5/19/17-pressure ri by 0.1 cm depth, ur drainage, stable.	educing mattress in place, ily. ght ischium, 3 cm by 0.5 cm, nstageable, no odor, no rn and reposition every 2 -2.5				
	hours. cover with fc 6/12/17-pressure rig by 0.1 cm depth, ur odor, improved, analysis-re	bam daily. ght ischium, 2.8 cm by 0.5 cm istageable, no drainage, no mains on 2-2.5 hour				
nnesota D	wound wash, santy	emains same. Cleanse with l (a collagenase ointment used briding ointment) to eschar,				

STATEMEI	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00149	B. WING		07/	28/2017		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET								
RED WII	NG HEALTH CENTER		ST FOURTH S NG, MN 55066	TREET				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
2 900	Continued From pa	ge 27	2 900					
	6/19/17-pressure rig 0.5 cm depth, press drainage, no odor, p analysis-remains sa every 2-2.5 hours, c santyl to escha change daily. 6/28/17-pressure rig by 0.5 cm depth, sta serosa progress-no change analysi reposition every 2-2 wound with foam dressing, 7/4/17-pressure righ no depth identified, scant a serosanguinous and odor-ye cleanse eschar, cover with f change analysi times a day, continu dressin reposition every 2-2 7/17/17-pressure rig 1.3 cm depth, unsta cleanse with wound eschar change daily, progre analysi drainage, eschar is	ame size, turn and reposition cleanse with wound wash, r, cover with foam dressing, age 3, moderate nguinous drainage, no odor, e, s-remains same size, 2.5 hours. cleanse with wash, santyl to eschar, cover change daily. nt ischium, 4.7 cm by 3.1 cm, unstageable, and moderate drainage, d green drainage es, e with wound wash, santyl to oam dressing, e daily. s- augmentin (antibiotic) two ue with current g change, remains on 5 hours. ght ischium, 5 cm by 3 cm by ageable, scant ge, serosanguinous, no odor, wash, santyl to , cover with foam dressing, ess-declined, s- no longer has green loosening and depth to be measured, remains on						

STATEMEI	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00149	B. WING		07/2	//28/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
RED WII	NG HEALTH CENTER		ST FOURTH S G, MN 55066	TREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	ge 28	2 900				
	7/24/17-pressure rig by 2 cm depth stag drainag ischial wound care- wound eschar/slough, cove dressir analysis-continue c medi-h 7/31/17 for debrider Document review o revealed the followi On 4/23/17 R23 on large red area appr inside red area is o right buttock upper On 6/2/17-returned today, continues to right gluteal fold me 0.5 cm in depth, ha facility. Also indicate right side in bed at 4 On 7/19/17 upon ca appeared to have n wound, this has hap week, also laying of side. The note state wound, complete be R23 so brief would note indicated a nei measured 5.3 cm b	eable pressure ulcer. ght ischium, 5 cm by 3.5 cm e 4, heavy ge, tan color, no odor, right cleanse with wash, apply medi-honey to er with foam ng, change every 8 hours, urrent treatment of noney, has appointment on ment of wound. of facility progress notes ing: rounds at 12:00 a.m. had oximately 5 cm by 3 cm, pen area 3 cm by 1 cm, on thigh crease. from hospital about 1 p.m. have trachea in, wound on easures 4 cm by 1.5 cm and d worsened since left the ed on 6/2/17, R23 was lying on 40 degrees angle. ares at 8:30 a.m., R23 to foam dressing over right hip ppened multiple times in last n right side and not on the left ed brief lines exactly on top of ed change and put pad under not irritate the wound. The w mark above the wound that by 3.5 cm. rea on right hip measured 2.5					

ta Department of He	ealth				
IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00149	B. WING		07/	28/2017
PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	1412 WE	ST FOURTH S	TREET		
IG HEALTH CENTER	RED WIN	IG, MN 55066			
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Continued From pa	ge 29	2 900			
lack of medi-honey indicated that on 7/19/17, 7/20/17, ar facility pharmacy to Document review o 7/25/17, revealed d	that was ordered on 7/17/17 nd 7/25/17, staff called the obtain medi-honey. If the right hip x-ray dated egenerative joint disease of				
the following orders On 7/14/17-repositi On 7/17/17-right iso wound wash, apply cover with foam dre	with start date: on every 2 hours. chial wound care, clean with medi-honey to eschar/slough, essing, change every 8 hours.				
progress notes reve On 3/14/17-skin wa lesions or wounds. On 4/11/17- sustain unstageable pressu on ischium. On 5/4/17-was hosy fecal impaction. Dia fracture diagnosed hospitalization, did hospitalization. Diag two decubitus right to hospitalization, a On 6/5/17-during as wound was found to	ealed the following: irm and dry, no suspicious hed a fall overnight and ure ulcer was found 3/28/17, pitalized 4/23/17 to 4/28/17 for agnosis included right hip incidentally during have a fall prior to gnosis also indicated a stage ischial ulceration found prior ppears to be worse. ssessment visit, the sacral o have no dressing in place.				
1	T OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER G HEALTH CENTER SUMMARY STA (EACH DEFICIENCC REGULATORY OR L Continued From pa Document review of lack of medi-honey indicated that on 7/19/17, 7/20/17, at facility pharmacy to Document review of 7/25/17, revealed d right hip and no evi at this time. Document review of the following orders On 7/14/17-repositi On 7/17/17-right iso wound wash, apply cover with foam dre On 7/25/17-X-ray ri osteomyelitis). Document review of progress notes revo On 3/14/17-skin wa lesions or wounds. On 4/11/17- sustair unstageable pressu on ischium. On 5/4/17-was hos fecal impaction. Dia fracture diagnosed hospitalization, di hospitalization, di hospitalization, dia to hospitalization, di hospitalization, di hospitalization, di hospitalization, di	OF CORRECTION IDENTIFICATION NUMBER: 00149 00149 PROVIDER OR SUPPLIER STREET AT 1412 WE RED WIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 Document review of progress notes related to lack of medi-honey that was ordered on 7/17/17 indicated that on 7/19/17, 7/20/17, and 7/25/17, staff called the facility pharmacy to obtain medi-honey. Document review of the right hip x-ray dated 7/25/17, revealed degenerative joint disease of right hip and no evidence to indicate osteomyelitis at this time. Document review of physician orders revealed the following orders with start date: On 7/14/17-reposition every 2 hours. On 7/17/17-right ischial wound care, clean with wound wash, apply medi-honey to eschar/slough, cover with foam dressing, change every 8 hours. On 7/25/17-X-ray right hip (evaluate for possible osteomyelitis). Document review of physician/nurse practitioner progress notes revealed the following: On 3/14/17-skin warm and dry, no suspicious lesions or wounds. On 4/11/17- sustained a fall overnight and unstageable pressure ulcer was found 3/28/17, on ischium.	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: 00149 B. WING	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: O0149 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE G HEALTH CENTER 1412 WEST FOURTH STREET RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER COSS-REFERENCE TO (EACH CORRECTIVE AC CROSS-REFERENCE) Continued From page 29 2 900 Document review of progress notes related to lack of medi-honey that was ordered on 7/17/17 indicated that on 7/19/17, 7/20/17, and 7/25/17, staff called the facility pharmacy to obtain medi-honey. Document review of the right hip x-ray dated the following orders with start date: Document review of physician orders revealed the following orders with start date: Dor 7/14/17-reposition every 2 hours. On 7/12/17-right ischial wound care, clean with wound wash, apply medi-honey to eschar/slough, cover with foam dressing, change every 8 hours. On 7/12/17-X-ray right hip (evaluate for possible osteomyelitis). Document review of physician/nurse practitioner progress notes revealed the following: On 3/14/17-sustained a fall overnight and unstageable pressure ulcer was found 3/28/17, on ischium. On 0/11/1/17 - sustained a fall overnight and unstageable pressure ulcer was found 3/28/17, on ischium. On 6/17-vars hospitalized 4/23/17 to 4/28/17 for fecat impaction. Diagnosis included right hip fracture diagnosed incidentally during hospitalization, did have a fall prior to hospitalization, appears to be worse. On 6/	TOF DEFICIENCIES OF CORRECTION (x1) PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING: (x3) DATA A BUILDING: ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE G HEALTH CENTER 1412 WEST FOURTH STREET RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION NUMBER: ID PROVIDER'S PLAN OF CORRECTIVE ACTION STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION STREET RED WING, MN 55066 ID PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION BODING) Continued From page 29 2 900 Document review of progress notes related to lack of medi-honey that was ordered on 7/17/17 indicated that on 7/19/17, 7/20/17, and 7/25/17, staff called the facility pharmacy to obtain medi-honey. Document review of physician orders revealed the following orders with start date: 0n 7/17/17r-right ischial wound care, clean with wound wash, apply medi-honey to eschar/slough, cover with form dressing, change every 8 hours. 0n 7/25/17-X-ray right hip (evaluate for possible osteomyelitis) Document review of physician/nurse practitioner progress notes revealed the following: 0n 3/14/17-skin warm and dry, no suspicious lesions or wounds. 0n /4/11/17- sustained a fall overnight and unstageable pressure ulcer was found 3/28/17, no ischium. 0n SofAl17-during assessment visit, the sacral wound was hospitalized 4/23/17 to 4/28/17 for facal impaction. Diagnosis also indicated a stage two decubitus right ischial ulceration found prior to hospitalization, appears to be worse. 0n 6/5/17-during assessment visit, the sacral wound was found to ha

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00440	B. WING		07/		
		00149			077.	28/2017	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
	IG HEALTH CENTER		ST FOURTH S IG, MN 55066				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	ge 30	2 900				
	no induration. The r	note indicated R23 was in the					
	emergency room ov	ver the week-end for elevated					
	temperature, consti	pation and chest x-ray					
		and started on antibiotics.					
	On 6/9/17-impression is pneumonia.						
		On 7/14/17-ordered to reposition every 2 hours to prevent excessive pressure to the area. R23 has					
		been referred to general surgery, had an					
		usly but was discontinued due					
		e facility to accompany to the					
		eschedule this for a very					
	needed debridemer						
	On 7/25/17- reveale	ed R23 was seen for acute					
		right ischial pressure ulcer.					
		on 7/14/17. R23 had a					
		nent with surgery on 7/7/17,					
		pressure ulcer. Physician was					
		oordinator today that this anceled due to no nursing staf	F				
		panying R23. Physician was					
		pointment had been made.					
		eration is malodorous,					
		, possible pain, pain					
	medication given w	ith good effect. Right ischial					
		was examined, wound bed					
		otic and larger than last exam.					
		grimacing when physician					
		of wound. Wound was					
		is a 2 cm red area on right hip Medi-honey was ordered after					
		hich physician was told, had					
		d . There is also a new area					
		per nursing notes on 7/22/17,					
		ed area which is blanchable. A					
		lied to this area. Physician					
		an-unstageable right ischial					
		a right hip X-ray to assess for					
		itis, will consider doing CT					
		tures, ordered blood work,					
	previous wound cul	ture was polymicrobial and					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00149	B. WING		07/28/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		1412 WF	ST FOURTH S			
	NG HEALTH CENTER	RED WIN	IG, MN 55066			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE
1110		,		DEFICIENC	CY)	
2 900	Continued From pa	age 31	2 900			
2000		-	2 000			
		(antibiotic) for 10 days.				
		nursing about medi-honey as				
		ailable. Nursing said it was				
		2 p.m. Physician asked for				
	appointment for debridement as this was canceled without physician knowing. Physician					
		is medically necessary and				
	should not be post					
		boneu.				
	Document review of	of hospital Consultation report				
		aled reason for exam was				
		d fever. Also noted right				
	buttocks stage 1 de	buttocks stage 1 decubitus ulcer, no erythema,				
	induration, drainage, bleeding or warmth, mepilex					
	border reapplied.					
	Document review of nursing progress notes					
	revealed the followi					
		eable pressure ulcer found on				
	ischium on 3/28/17					
		ge red area approximate 5 cm				
		area is open area 3 cm by 1				
		upper thigh crease, area				
		dressing applied, positioned				
	to off- load pressure					
		progress note identified				
		wound, clean with wound oney to eschar/slough, cover				
		, change every 8 hours.				
	Dunin a interview or	7/05/47 -+ 0.00 0.001-				
		7/25/17 at 9:33 a.m., R23's				
		0)-A stated R23 had a new ure ulcer which started in the				
		ed on three occasions found no				
		und and have found R23				
		nstageable wound. MD-A				
		e debridement appointment				
		use no staff were available to				
	go with R23 to the	appointment. MD-A stated had				
		treatment recently to				

Minneso	ota Department of He	alth			FORM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00149	B. WING		07/28/20	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	NG HEALTH CENTER	1412 WES	ST FOURTH	STREET		
		RED WIN	G, MN 5506	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 32	2 900			
	medi-honey and was not aware that the facility had not obtained the ointment timely.					
Minnesota D	director of nursing (R23 to be reposition according to the cal expected R23 was right side open wou perineal care after of R70's Minimum Dat indicated R70 had r required assistance mobility and had a of MDS further indicat pressure ulcer and pressure ulcer. The a pressure ulcer. The a pressure reducing received pressure u ointments/medication Kardex Report print was to be assisted every 2 hours-2.5 h members and off lo every 2 hours. The was to have a heel heels off the bed all for incontinence even R70's Treatment Ac dated 1/16/16, indic was to ensure that a for turning, reposition A Turn and Reposit Plan Task Sheet for marks for every shi 6/27/17, and 7/25/1 was conducted on T	ta Set (MDS) dated 5/11/17, no cognitive impairment, of two persons for bed diagnosis of quadriplegia. The ed R70 had one stage III was at risk of developing a MDS also indicated R70 had g device for his chair and bed, alcer care and applications of ons. R70's Visual/Bedside ted on 7/27/17, indicated he with turning and repositioning ours with an assist of two staff ad when in his wheel chair report further indicated R70 elevating cushion to keep the time, and to be checked				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00149	B. WING		07/	//28/2017	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		20/2011	
	IG HEALTH CENTER	1412 WE	ST FOURTH S	TREET			
		RED WIN	IG, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 33	2 900				
	through 7/26/17, re 4/17/17, left lateral length, 1 centimete unstageable depth. measurement only: left lateral foot mea x unstageable and unstageable. 7/24/ measurements: an and posterior 0.25 right heel scar tissu 4 x stage II. During continuous 7:05 a.m. to 10:24	terior 0.5 x 0.5 x unstageable x 0.25 unstageable. 7/26/17, ue 1.5 x 1.0 and coccyx: 4.5 x observation on 7/26/17, from a.m. (3 hours and 19 minutes)					
	without being repose checked for inconti queried two staff m Nurse (RN)-A and regarding reposition	laying in his bed on his back sitioned (off loaded) or nence. At 10:24 a.m. writer nembers in hallway, Registered RN-B, and voiced concern ning of resident. Resident was sitioned and his right heel was d.					
	RN-A confirmed R7 repositioned since had been resting of confirmed there wa area on R70's right coccyx area had a area. RN-A stated I turned and reposition	10 a.m. during an interview, 70 had not been turned or 7:05 a.m. and his right heel n the bed. RN-A and RN-B as a quarter sized darkened t heel and his skin over the half dollar sized pink/white R70 should be checked on, oned every 2 hours and his been elevated off of the bed.					
	R70 he stated he is	95 a.m. during an interview with s not turned and repositioned ery shift and when that	1				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00149	B. WING		07/2	28/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH S G, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 34	2 900			
	happens I get stiff a opening up.	and worry about my skin				
	Nursing Assistant (I	9 p.m. during an interview with NA)-A confirmed R70 should sitioned every two hours.				
	DON stated her exp repositioning reside	a.m. during an interview, pectations for turning and ents would be based on eflected in the resident's care				
	RN-A stated she ha he had a new press that was not preser heel has an area of will monitor to see i scar tissue. RN-A fu	a.m. during an interview, ad reviewed R70's wounds and sure ulcer to his coccyx area at one week ago and his right scar discoloration which she f it is a pressure ulcer or old urther indicated that turning f R70 needs to be done every ds could develop.				
	RN-A stated docum missing check marl repositioning log be	p.m. during an interview, nentation by NAs had multiple ks under R-70's turning and tween 6/27/17, and 7/25/17, n if R70 was repositioned or				
	and Procedures da Preventive Measure staff to change resi	ion of Pressure Ulcers Policy ted 2/2014, General es for a Person in Bed directed dent's position at least every frequently if needed.				
		ges defined by the National isory Panel (NPUAP):				
	Stage 1: Nonblanch	nable Erythema: Intact skin				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00149	B. WING		07/	28/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	NG HEALTH CENTER		ST FOURTH S			
		RED WIN	NG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 35	2 900			
	usually over a bony pigmented skin ma its color may differ The area may be pa cooler as compared Stage 2: Partial Thi thickness loss of de open ulcer with a re slough. May also pr open/ruptured seru	e redness of a localized area prominence. Darkly y not have visible blanching; from the surrounding area. ainful, firm, soft, warmer or d to adjacent tissue. ckness Skin Loss: Partial ermis presenting as a shallow ed pink wound bed, without resent as an intact or m-filled blister. Presents as a v ulcer without slough or				
	skin, in which adipc and granulation tiss edges) are often pr devitalized tissue, ti adherent on the tiss dead tissue) may b tunneling may occu ligament, cartilage If slough or eschar	Ilcer: Full-thickness loss of ose (fat) is visible in the ulcer sue and epibole (rolled wound esent. Slough (yellow hat can be stringy or thick and sue bed) and/or eschar (dark, e visible. Undermining and ir. Fascia, muscle, tendon, and/or bone are not exposed. obscures the extent of tissue ageable Pressure Ulcer.				
	tissue loss with exp fascia, muscle, tend bone in the ulcer. S visible. Epibole (roll and/or tunneling oft	Ilcer: Full-thickness skin and losed or directly palpable don, ligament, cartilage or clough and/or eschar may be ed edges), undermining renoccur. If slough or eschar t of tissue loss this is an ure Ulcer.				
	full-thickness skin a skin and tissue loss	ure Ulcer: Obscured and tissue loss. Full-thickness in which the extent of tissue ulcer cannot be confirmed				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00149	B. WING		07/	28/2017
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	NG HEALTH CENTER	1412 WE	ST FOURTH S	STREET		
		RED WIN	NG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE ⁻ DATE
2 900	Continued From pa	age 36	2 900			
	slough or eschar is 4 pressure ulcer wi (i.e. dry, adherent, fluctuance) on the not be softened or Deep Tissue Press non-blanchable de discoloration. Intac localized area of per red, maroon, purple separation revealin filled blister. If necr tissue, granulation underlying structure	ured by slough or eschar. If a removed, a Stage 3 or Stage ill be revealed. Stable eschar intact without erythema or heel or ischemic limb should removed. sure Injury: Persistent ep red, maroon or purple et or non-intact skin with ersistent non-blanchable deep e discoloration or epidermal ng a dark wound bed or blood rotic tissue, subcutaneous tissue, fascia, muscle or other es are visible, this indicates a sure injury (Unstageable, Stage				
	General Guidelines Indicated pressure when a resident re an extended period pressure or a decre to that area and su The most common where the bone is a pressure ulcers are continual pressure substances on resi feces, urine, wound decline in nutrition illness and/or decli or mental condition Interventions and F change position at	sure Ulcers dated 2/2014: ulcers are usually formed mains in the same position for d of time causing increased ease of circulation (blood flow) bsequent destruction of tissue a site of a pressure ulcer is near the surface of the body. e often made worse by , heat, moisture, irritating ident's skin (i.e., perspiration, d discharge, soap residue, etc) and hydration status, acute ne in resident's physical and /				

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00149	B. WING		07/	28/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH S [.] G, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	every 2 hours and c Perineal Care policy For male indicated- wipes, wet wash clo spray or use perines urethra and work ou penis, scrotum, inner reposition and wash Skin Program policy Indicated to ensure facility without press pressure ulcers unle condition demonstra unavoidable. on ad of skin status done further comprehens done with readmiss condition or surface assessment will be is identified. SUGGESTED MET The director of nursing of care. The director of residents at risk for they are receiving th treatment/services to from developing and pressure ulcers. Th conduct random au ensure appropriate	and Bladder for incontinence at least clean skin when soiled. y dated 10/2015: if stool present use perineal oth and apply skin cleansing al wipes, wash starting with utward, retract foreskin, wash er thighs, gently pat dry. n rectal area. y dated 9/2016: a resident who enters the sure ulcers does not develop ess the individuals clinical ates that they were mission, baseline assessment within 2 hours of admission. sive skin assessments will be ion, annually, and change of e comprehensive wound completed when a skin ulcer HOD OF CORRECTION: ing could review and revise ures for pressure ulcers. The could educate all staff on skin of nursing could review all pressure ulcers to assure		DEFICIENC	21)	

5Z1K11

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00149	B. WING		07/28/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	IG HEALTH CENTER		6T FOURTH G, MN 5506		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET
2 900	Continued From pa	age 38	2 900		
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910		8/31/17
	have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the sident assessment, a nursing that: who enters a nursing home ng catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as ler function as possible.			
	by: Based on observat review, the facility f cares/services to p	ent is not met as evidenced ion, interview and document failed to provide necessary revent urinary tract infections sidents (R64, R125) reviewed		see POC	
	Findings include:				
	to the admission sh record indicate R64 urinary obstruction,	to the facility 8/18/15 according neet. Review of the medical 4 to have current diagnoses of , urinary retention (inability to he bladder), hydrocele (an			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00149	B. WING		07//	28/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NG HEALTH CENTER		ST FOURTH S IG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 910	Continued From pa	ge 39	2 910			
	phimosis (an inabili	id around the testicles), ty to retract the foreskin over nary tract infection (UTI).				
	R64 was in bed with unsnapped and the bag uncovered and At 8:12 a.m. nursing room to assist with provide pericare or partial bath. NA-J a	ion on 7/26/17, at 7:15 a.m. h the catheter bag cover lower quarter of the catheter in direct contact with the floor g assistant (NA)-J entered the morning care and did not catheter care during the ssisted R64 to wheelchair ter bag above resident				
	no training at the fa catheter care and it nursing assistant co was unaware of the below the bladder lo reentering into the l	NA-J stated she had received cility related to the provision of was briefly taught during her burse the previous fall. NA-J e need to keep catheter bag evel to prevent urine from bladder. NA-J unable to recall eter cleaning instruction.	F			
	licensed practical n to find providing cat	on 7/26/17, at 1:57 p.m. with urse (LPN)-A, she was unable theter care on the treatment unable to state if it was being				
	7/28/17, at 8:34 a.n access to the plan of catheter care is del	egistered nurse (RN)-A on n. revealed that NAs have of care and that providing egated to the NAs and the e to see that it is done.				
	urology dated 1/17/ complete pericare f	or R64 including a note from 17, directed staff to "please for pt [patient/R64]!" A note poctor, indicated on 7/20/17,				

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		00149	B. WING		07/	28/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH S IG, MN 55066	TREET		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETE DATE
2 910	Continued From pa	ge 40	2 910			
	interactive. The curr instruction to keep of bladder but no direct catheter care. R125's Minimum Da indicated R125 had impairment, a diagr cancer and an indw Care Plan dated 5/2 assistance with urin having an indwelling Medical doctor (MD identified R125 had severe, and he is ur medical decisions. Medical Doctor Ord antibiotics for a UTI another UTI from 5/2 Observation on 7/24 lying in bed sleeping tubing running down bag was in a blue c floor in front of the k On 7/25/17, at 10:11 wheelchair in his ro on the floor as R125	hosis of malignant bladder relling Foley catheter. 1/17, identified R125 needed hary function related to R125 g Foley catheter.) progress note dated 6/16/17 Alzheimer's dementia. This is hable to make his own ers identified R125 was on from 5/13 -5/23/17, and '31/17 - 6/7/17. 1/17, at 3:30 p.m., R125 was g with the Foley catheter h his left leg and the catheter loth bag lying directly on the				
	sleeping in bed with	a.m., R125 observed to be wheelchair parked in front of a bag still connected to left				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00149	B. WING		07/28/2017	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	1 01120120	
	IG HEALTH CENTER		ST FOURTH S			
		RED WIN	IG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ge 41	2 910			
	wheeling self in whe the common area. hanging off the left wheelchair. Dark ye pooled in the bottor dragging on the floo Interview on 7/27/17 assistant (NA)-E sta catheter bag on the wheelchair because further stated she d backflow into R125 was not positioned	a.m., R125 observed eelchair down the hall towards R125's catheter bag was side of his armrest of his ellow urine is noted to be n of the catheter tubing that is or. 7, at 7:59 a.m., nursing ated that R125 always puts his e left side of his arm rest on his e he transfers himself. NA-E lid not realize that urine could 's bladder if the catheter bag below the bladder level and 125 at a higher risk to develop				
	wheeling self to din hanging off the whe urinary tubing was of floor, R125 was run this surveyor notifie this time RN-D state to drain with his cat side of his arm rest further stated, "I do	a.m., R125 observed to be ing room with his catheter bag eelchairs left arm rest and coiled and dragging on the ning over his own tubing until d RN-D of the event. During ed that R125's urine is unable heter bag hanging off the left on his wheelchair. RN-D n't know what the answer is up to the table so he can				
	of nursing (DON) ve be to have the resid hanging below the l	7/27/17, at 8:53 a.m., director erified her expectation would lent's catheter bag to be bladder to allow proper nd to help prevent a UTI.				
nnoosto D	revised November 2	atheter Care," dated 2010, 2016, indicates to check the to be sure he is not lying on				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00149	B. WING		07/28/201	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH G, MN 5506	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ge 42	2 910			
	free of kinks. The u held or positioned le times to prevent the drainage bag from bladder. Infection (catheter tubing and floor.	keep the catheter and tubing urinary drainage bag must be ower than the bladder at all e urine in the tubing and flowing back into the urinary Control identifies, be sure the drainage bag are kept off the				
	The director of nurs all residents with ar assure they are rec treatment/services infections and to re function as possibl designee, could con	HOD OF CORRECTION: sing or designee, could review in indwelling Foley catheter to reviewing the necessary to prevent urinary tract store as much normal bladder e. The director of nursing or induct random audits of the ensure appropriate care and inented.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			8/31/17
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview, and record ailed to provide assistance with I by the care plan for 1 of 4		see POC		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00149	B. WING		07/	28/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
	NG HEALTH CENTER		ST FOURTH S	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 43	2 920			
	services/cares for 1	I failed to provide incontinence of 4 residents (R23) for both reviewed for activities of daily				
	Findings include:					
	5/2/17, identified R6	imum Data Set (MDS) dated 32 with severe cognitive uired extensive assist of 1 ne.				
		ed 6/25/15, identified R63 with ssistance with shaving or upon discovery.				
	resident cares) date grooming needs as	ng assistant assignment for ed 7/27/17, identified R63's sist with shaving or pluck covery per R63's wishes.				
	was sitting on the co during a scheduled noted to have seven During subsequent 9:35 a.m., 7/26/17,	on 7/24/17, at 4:07 p.m., R63 ouch in the common area singing activity and R63 was ral long unshaven chin hairs. observations on 7/25/17, at at 12:53 a.m., and on 7/27/17, ontinued to have long, s.				
	assistant (NA)-B ve	7/26/17, at 1:52 p.m., nursing rified that R63 should have her stated R63 does not have haver to be shaved.				
	verifies that R63 ne	on 7/26/17, at 1:57 p.m., NA-C eds 1 assist to help with e plan and that R63 should nairs shaved.				

00149B. WINAME OF PROVIDER OR SUPPLIERSTREET ADDRESSRED WING HEALTH CENTER1412 WEST FO RED WING, MN(X4) ID PREFIXSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PR PR T.2 920Continued From page 442 92During interview on 7/27/17, at 7:48 a.m., registered nurse (RN)-D verified that R63 should have had her chin hairs shaved and stated, "This is my worst fear living in a nursing home and to have all those facial hairs."2 92Interview on 7/27/17, at 8:51 a.m., director of nursing (DON) verified her expectation is to shave each resident as needed and to follow the care plan as directed. DON further stated they would contact social services to get R63 a personal shaver. R23 was admitted to the facility on 7/14/16, according to facility Admission Record.R23 had diagnosis that included acute respiratory failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures, according to facility physician progress note dated 7/25/17.Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired	, CITY, STATE, ZIP CODE URTH STREET 55066 ID PROVIDER'S PLAN OI EFIX AG CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE
NAME OF PROVIDER OR SUPPLIERSTREET ADDRESSRED WING HEALTH CENTER1412 WEST FO RED WING, MN(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PR2 920Continued From page 442 92During interview on 7/27/17, at 7:48 a.m., registered nurse (RN)-D verified that R63 should have had her chin hairs shaved and stated, "This is my worst fear living in a nursing home and to have all those facial hairs."2 92Interview on 7/27/17, at 8:51 a.m., director of nursing (DON) verified her expectation is to shave each resident as needed and to follow the care plan as directed. DON further stated they would contact social services to get R63 a personal shaver. R23 was admitted to the facility on 7/14/16, according to facility Admission Record.R23 had diagnosis that included acute respiratory failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures, according to facility physician progress note dated 7/25/17.Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long 	, CITY, STATE, ZIP CODE URTH STREET 55066 ID PROVIDER'S PLAN OI EFIX AG CROSS-REFERENCED TO DEFICIEN	F CORRECTION (X5) TION SHOULD BE COMPLET THE APPROPRIATE DATE
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failure with hypoxia, traumatic brain injury, neurogenic bowel, neuromuscular dysfunction of bladder and seizures, according to facility physician progress note dated 7/25/17. Facility identified R23 on the quarterly Minimum Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired		
Data Set (MDS), 4/4/17, to have short and long term memory problem, severely impaired		
decision making, totally dependent on two staff for activities of daily living which included bed mobility, transfers, dressing, toileting and hygiene, always incontinent of bowel and bladder, pain unable to answer, functional limitation in range of motion on both sides, unstageable pressure ulcer due to slough or eschar, pressure ulcer not present on prior assessment, feeding tube, tracheostomy, suctioning, oxygen.		
The facility identified R23 on the annual MDS dated 6/19/17, same as 4/4/17 MDS, and was identified with no pain.		
Document review of R23's Bladder and Bowel		

Minnesc	ta Department of He	alth				APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00149	B. WING		07/28/20	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		1412 WES	T FOURTH S	TREET		
	IG HEALTH CENTER	RED WING	G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 45	2 920			
	included impaired n staff for transfers, o bladder, clothes and Analysis indicated i bladder, has diagno staff assist R23 with Review of R23's ca included the followin Care plan problem bowels and bladder check incontinence minus 15 minutes a	6/19/17, identified risk factors nobility and dependent on two surrently incontinent of d incontinent product is wet. ncontinent of bowel and osis of neurogenic bladder and n all toileting needs. re plan print dated 7/26/17, ng directions for staff: of always incontinent of . Interventions included: e product every 2 hours plus or and as needed, change as betective skin care with each de.				
	Report (NA assignm directed to turn and with two staff assist dependent on staff, 2-2.5 hours, inconti check incontinence plus/minus 15 minu provide protective s incontinence.					
	nursing assistant (N Observation at that positioned slightly of back, facing the do incontinent brief an were wet. Observat incontinent brief wa Observations at tha R23 with a clean in bedding. However,	s on 7/26/17, at 8:58 a.m., NA)-D entered R23's room. time revealed R23 was on right side with a pillow to the prway. NA-D checked R23's d verified the brief and bed ions at that time revealed the s heavily saturated. It time revealed NA-D provided continent brief and clean no perineal care was ne new incontinent brief was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		ST FOURTH S IG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 46	2 920			
	put on the resident. NA-D verified had not provided perineal care after incontinence.					
		d practical nurse-B stated d be done after every de.				
	bowel and bladder, with each incontine protective skin care after each incontine	s care plan for incontinence of directed protective skin care nt episode. RN-A stated was the use of barrier cream ence. RN-A said staff were perineal cares with each de.				
	director of nursing (7/26/17, at 12:01 p.m., (DON) stated she expected ded after each incontinence.				
	male indicated if sto wipes, wet wash clo spray or use perine urethra and work or	y dated 10/2015 included, for ool present use perineal oth and apply skin cleansing al wipes, wash starting with utward, retract foreskin, wash er thighs, gently pat dry, n rectal area.				
	The director of nurs employees respons for residents the ne	HOD OF CORRECTION: sing could in-service all sible for providing direct cares ed to follow the residents e plan. Also to monitor for				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program) Subp. 1 Infection Control;	21375			8/31/17

Minneso	ta Department of He	alth				ATTROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00149	B. WING		07/2	8/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 47	21375			
	home must establis	on control program. A nursing th and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review, the facility f hygiene procedures	ent is not met as evidenced on, interview, and document ailed to ensure proper hand were followed by staff for 1 of served receiving morning care ad of infection.		see POC		
	Findings include:					
	when nursing assis hands after providir included using wipe incontinent of stool. brief in a plastic bag and left R64's room soiled brief. NA-J f following cares for l a.m. NA-J was obsi- resident's room app uncovered resident would like to get up gloves in the room, lift." NA-J left the re- the standing lift.	NA-J disposed R64's soiled g. NA-J removed her gloves a, taking the bag containing the had not washed her hands R64 and immediately at 8:40 erved going into another proached the bedside, and asked the resident if she for breakfast. NA-J donned then stated "let me get the sident's room and retrieved				
	was asked about ha had not washed he and doing peri care	d to the resident's room, she andwashing. NA-J verified she r hands after removing gloves for R64. NA-J stated I usually g desk after cares and wash nervous today.				
/linnesota D STATE FORI	epartment of Health Vl		6899	5Z1K11	If continuatio	n sheet 48 of 56

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00149	B. WING		07/28/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	NG HEALTH CENTER		ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 48	21375			
	Handwashing/Hygie their hands for at le before and after as care and after hand SUGGESTED MET The director of nurs staff responsible for monitor for ongoing	cility policy dated 10/14 entitled ene, employees must wash ast twenty (20) seconds sisting a resident with personal lling soiled or used linens. THOD OF CORRECTION: sing could give education to all r preventing infection. Also to p compliance. R CORRECTION: Twenty-one				
21426	MN St. Statute 144, Prevention And Cor	A.04 Subd. 3 Tuberculosis htrol	21426			8/31/17
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implemen	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of e technical assistance intation of the guidelines.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		00149	B. WING		07/28/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21426	Continued From pa	ge 49	21426			
	by: Based on interview facility failed to ensight employees (E-A, E- months had eviden and tuberculosis sk 1 of 6 newly hired en- past four months had failed to ensure 2 of evidence of tubercular and failed to ensure	ent is not met as evidenced and document review, the ure 2 of 6 newly hired F), within the past four ce of tuberculosis screening in tests (TST); failed to ensure employees (E-D) within the ad TST results interpretation; f 5 residents (R92, R42) had ulosis screening on admission; e 4 of 4 residents (R95, R84, ed first and/or second step		see POC		
	Tuberculin Skin Tes Healthcare Worker and first day workin following informatio SCREENING AND E-A had hire date o with residents was symptoms was com step TST was admi review of documen TST form was date original sheet. E-F had hire date o with residents was	n 7/25/17, of facility Baseline sting (TST) and Screen for s (HCWs), facility new hires g information, revealed the n:				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00149	B. WING		07/	28/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
	NG HEALTH CENTER		ST FOURTH S IG, MN 55066	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21426	Continued From pa	ge 50	21426			
	administered 5/12/ results of negative a Second step TST w read on 5/26/17, wi no indication of the as positive or negat RESIDENTS: R42 was admitted t There was no evide TUBERCULIN SKII R92 was admitted t	to the facility on 5/26/17. Ence of symptom screening.				
	of negative and 0 m date the first step w second step TST of	nm. There was no evidence of /as read. R92 was given n 8/3/16, with results of . There was no evidence of				
	There was no evide step TST. R95 was 10/27/16, with resu	to the facility on 10/13/16. ence that R95 received first s given second step TST on lts of negative. There was no e second step was read and n of induration.				
	There was no evide step TST. Second There was no evide was read and no ev	to the facility on 2/22/16. ence that R84 received first step TST was given on 3/7/16 ence of date the second step vidence of mm of induration of positive or negative.				
	There was no evide step TST. R107 wa 3/21/17, with results	to the facility on 3/7/17. ence that R107 received first as given second step TST on s of negative and 0 mm. ence of date the second step				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00149	B. WING		07/28/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH S NG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	ige 51	21426			
	was read.					
		to the facility on 5/26/17. ence of first and second step				
		of facility Tuberculosis ntrol Program dated 7/2014, ing:				
	1. A resident's clinic report of a tuberculi prior to admission of admission. F the fi second step will be weeks after the first	uberculosis Program: cal record must contain a in test within three months or within 72 hours after rst step TST is negative, a completed one week to three t test is read. Risks/History een must also be completed.				
	Workers: 1. All healthcare wo facility will be tested volunteering.	is Control Plan for Health Care orkers and volunteers of the d prior to employment or so include risk/history and	3			
	director of nursing (symptom screening completed at time of	7/28/17, at 8:15 a.m., (DON) verified although g are not dated, they are of first step TST. DON verified ation of negative or positive				
		7/28/17, at 11:20 a.m., DON no further evidence of g and TST.				
		HOD OF CORRECTION: sing could review/revise				

	ta Department of He	(X1) Provider/Supplier/Clia				
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00149		B. WING		07/28/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 52	21426			
	employee Tubercul	ures for resident and osis screening and perform policy was being followed.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21665	MN Rule 4658.1400) Physical Environment	21665			8/31/17
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible.				
	by: Based on observati review, the facility fa environment that wa repair for 5 of 89 re (R86) rooms with le hallways, tub rooms	as clean, sanitary and in good sident rooms, 1 of 1 resident eaking bathroom ceiling and s, dining room and family f 1 resident (R2) with a		see POC		
	Findings include:					
	observed during a t 7/28/17, at 8:30 a.m	s and concerns were our with the administrator on n. eiling tile with large brown				
	2E20-2-closet door against the wall.	off the tracks and leaned				
	2E44-2-TV cable ha	anging down near the				
inesota De	epartment of Health			1		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED 07/28/2017	
		00149			07/		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	EET ADDRESS, CITY, STATE, ZIP CODE				
	IG HEALTH CENTER		ST FOURTH S NG, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21665	Continued From page 53		21665				
	doorway.						
	7/26/17, at 10:50 a. long tailed flying but observed on the co- dead ant on bathroo floor, many dead gr bedside stand and o Observations during the Administrator or revealed dead gnat stand, large area of ceiling instead of cei inches wide area th exposed pipes abov During interview at the facility has a roo water from the roof located next to the facility has a roo water from the roof located next to the facility pipes were v bugs on the bedside pest control was at Document review o Report Form dated written concern of le A temporary fix was ago which included No further action ha This concern was b Ombudsman. Actio R86 to another roor	g the environment tour with n 7/28/17, at 8:30 a.m., s (small flying bug) on bedside i hard plastic on bathroom eiling tile, with approximately 3 e length of the plastic that we the ceiling. that time, Administrator stated of leak, the hose is draining into the wastebasket (which is toilet). Administrator verified e stand. Administrator verified e stand. Administrator stated the facility every 30 days. f facility Grievance/Concern 3/15/17, revealed hand eak in R86's bathroom ceiling. s put into place several weeks a pipe draining into a bucket. ad been taken by the facility. rought up by the on taken was offered to move m, R86 refused to move.	3				
	3w80-1-bathroom c	eiling tile with brown stains.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00149		B. WING		07/	07/28/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	IG HEALTH CENTER		ST FOURTH S IG, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
	 200 west wing carpet stained and loose in areas. 300 wing hallway carpets stained. 300 wing family lounge peeling plaster, brown ceiling stains. 300 wing dining room doorway with peeling plaster, brown stains on ceiling above doorway. 300 north wing-free standing fan on 300 north hall thick dust. 		1				
	provided that addres building. During interview at 7/28/17, at 8:30 a.n areas of concern. computer system to of needed repairs. this every day. Fac meeting every morn department heads rounds room check R2's wheelchair ha 12:29 p.m. the right wheelchair were no with exposure to th of the foot straps w down towards the f facility offered to fix stated, "Nope!" R2 care plan reads mobility." The interv for unpleasant odor wheelchair cushion needed.	d been observed on 7/26/17 at t wheelchair arm on R2's oted to be torn and cracked, e metal frame as well as one ere broken off and hanging loor. R2 had been asked if the t the arm of the wheelchair. R2 , "I do use a wheelchair for vention is for staff to monitor rs and clean/replace s/covers/equipment when					
		on 7/27/17 at 11:31 a.m. with N)-A stated when things need					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00149	B. WING		07/28/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	IG HEALTH CENTER		ST FOURTH S	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	-	21665			
		ced staff are to update the tment on their computer LL."				
	Interview on 7/27/17 at 12:54 p.m. with director of nursing (DON) stated the facility cannot fix R2 wheelchair because hers is custom and if they attempt can void the warranty of the manufacturer. R2 is placed in her custom wheelchair on a daily basis. DON stated her expectation of staff would have reported the damage to the wheelchair maker before now.		f			
	which the DON sup audits completed for resident equipment and verified there w	on 7/27/17 at 2:19 p.m. in oplied the surveyors with daily or each room including to DON reviewed the audits vas no documentation, which ed R2 damage to the				
	a.m. stated each wi identify areas that r	nistrator on 7/28/17 at 9:38 ing is gone through daily to need addressed. Administrator air should been identified er daily rounds.				
		e maintenance of resident uested, but not supplied.				
	administrator and/o monitor equipment	HOD OF CORRECTION: The r maintenance director could and the physical plant for ning and sanitizing.	•			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				